Michigan Department of Education
Office of School Support Services

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:
4. Name of Participant/Student:		5. Participant Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician currently managing the disability care of this participant/student must sign this form.**

☐ Participant *does not have a disability*, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are not required to make accommodations when there is not a documented disability but may make accommodations for reasonable requests at their discretion. **A licensed physician, physician's assistant, registered dietitian, or nurse practitioner must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility.

Product Name: _____ **Meets Requirements?** ☐ Yes ☐ No ☐ Unsure

Reason for request: _____ Please skip to #15.

A licensed physician, physician's assistant, registered dietitian, nurse practitioner, or parent/guardian may sign this form.

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*describe in detail to ensure proper implementation-attach additional pages as needed*)

12. Foods to be omitted and substitutions: (*list specific foods to be omitted and suggested substitutions - attach additional pages as needed.*)

Food(s) To Be Omitted:	Suggested Substitution(s):

13. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

15. Signature of Parent/Guardian:	16. Printed Name:	17. Date:	
18. Signature of Medical Authority:	19. Printed Name with credentials:	20. Telephone:	21. Date: