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Special Diets: Prevalence and Policy Findings from Texas and Indiana School Districts

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KEYWORDS: school nutrition, special diets, food allergies, dietary accommodations

INTRODUCTION:

The National School Lunch Program (NSLP) is the second-largest food and nutrition assistance program in the United States (US), serving 4.9 billion meals in 2022 (Toossi et al., 2023). Participating school districts can operate the NSLP and other programs, such as the School Breakfast Program (SBP) offered through the United States Department of Agriculture (USDA), to provide children with healthy, low- to no-cost meals. These programs follow established meal patterns, composed of necessary components that must be offered to all students, ensuring nutritionally balanced meals.

The Rehabilitation Act of 1973 prohibited discrimination based on a disability for any federally funded program (US Department of Agriculture Food and Nutrition Service, 2017). Specifically, Section 504 of the act states that a person with a disability should not be excluded or denied benefits from participating in any program receiving federal financial assistance (US Department of Education, Office of Civil Rights, 2010). The Americans with Disabilities Act (ADA) was amended in 1990 to include discrimination based on disability in public and private schools. In 2008, the definition of disability was expanded in the ADA Amendments Act of 2008 to "a physical or mental impairment that substantially limits one or more major life activities of such individual" (US Department of Agriculture Food and Nutrition Service, 2017, p. 8). This expansion mandated food accommodations that meet this definition, including food allergies, food intolerances, and others, such as texture sensitivities.

Special dietary modifications that cannot be made within the established meal pattern of the program need a statement signed by a recognized medical authority for the program to receive reimbursement for that meal (US Department of Agriculture Food and Nutrition Service, 2017). Modifications that impact menu planning are referred to as special diets. While schools in federal programs must accommodate any requests that meet the definition of a disability, accommodating special diet requests based on cultural, religious, or personal reasons is optional (US Department of Agriculture Food and Nutrition Service, 2017). As a result, districts may address these requests in different ways. Additionally, school administrators may implement policies related to medically necessary special diets, such as banning or not serving certain food allergens.

To our knowledge, only one published paper quantified all types of medical accommodations in school meals, dating back over 30 years (Yadrick & Sneed, 1994). Since this time, not only have there been major guideline changes, but there has also been a rise in the need for accommodations, notably for food allergies. The

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prevalence of food allergies has been significantly increasing over the past two decades, with recent estimates indicating that around 8% of children in the US have food allergies (Gupta et al., 2018; Keet et al., 2014). In this paper, we aim to quantify the amount and types of special diets and explore practices school districts use to accommodate these special diets in a sample of districts in Texas and Indiana.

METHODS:

A Qualtrics survey was distributed to child nutrition professionals in Texas and Indiana between June and September 2022 (Qualtrics, Provo, UT). Texas and Indiana were chosen as the focus of this analysis based on the lead author's engagement with child nutrition professionals in these two states.

Participant Recruitment

Participants were recruited in multiple ways. First, an email list was created using emails on district websites. Second, state-wide child nutrition professional groups in both states were asked to share a link to the survey. Lastly, those who had taken the survey were encouraged to share it with child nutrition professionals in other districts. To assess the representativeness of the sample, district-level demographic characteristics were compared to total student enrollment demographics for both states.

As positions within a child nutrition management team vary, directors were targeted for recruitment. Survey instructions specified that respondents should be individuals with access to district-level information on special diets, such as directors or senior members of the child nutrition management team. Indiana University's Institutional Review Board approved the research protocol and survey (#15343).

Survey Development

Electronic consent for participation was collected prior to the beginning of the survey. The survey questions were developed based on an exploratory scope of current understanding of special diets. The survey was piloted with two foodservice professionals who provided feedback, and modifications were made before sending it out.

The survey had three parts. Part one included the name of the school district, city, and position of the respondent. In part two, participants were asked to report on special diet accommodations. An accommodation included any way that child nutrition professionals could potentially deviate from the meal pattern, including those made based on sources such as special diet forms, Section 504 plans, and Individualized Education Programs (IEPs). Six categories of special diets included (1) metabolic and autoimmune disorders, (2) texture modifications, (3) formulas and tube feedings, (4) allergies, (5) non-life-threatening disabilities and intolerances, and (6) energy and nutrient modifications. These categories were modeled after the only published study of special diets in schools (Yadrick & Sneed, 1994). The only change made to the categories was to separate allergies and intolerances into distinct categories based on known trends in child nutrition programs. Based on published data, the most likely responses were listed within the categories, and an "other" category was listed

at the end of each section for participants to explain any additional special diets in that category. For example, the top nine most common allergies were listed under the allergy category. Participants could enter how many of these allergies they are currently accommodating and report how many "other" allergies they are accommodating. Then, they could use the free text box to list these other allergies. After they provided responses in these six categories, another box prompted them to list any other special diets not already reported. These "other" responses were reviewed and assigned to an existing category when possible or reported separately if no category was appropriate.

In part three, we asked participants about their current food service policies regarding accommodating meals beyond the standard meal pattern. Questions included how common foods subject to modification, such as peanuts, fish, and milk substitutes, are handled and whether accommodations for personal or religious preferences are provided within their district. Preliminary questions were developed by researchers based on focus group findings and guided by the RC Model. Questions were reviewed until all authors agreed on the final survey questions.

Survey District Population Data

District-level population statistics were compiled from publicly available state databases using survey-reported school district names and cities (Indiana: https://indianagps.doe.in.gov/; Texas: https://rptsvr1.tea.texas.gov/adhocrpt/adstc.html) from the 2021–2022 school year. Counts of total enrollment, race and ethnicity, and economically disadvantaged (ED) percentages were used to provide a demographic profile of districts represented in the survey sample and the total student population of both states. Additionally, each district was classified using USDA 2013 rural-urban continuum codes based on the self-reported city (U.S. Department of Agriculture, Economic Research Service, 2013). These district-level measures were collected and reported to assess the representativeness of the sample.

Data Analysis

All special diets reported were counted as a single event, even if one student had more than one special diet, as each special diet is a different accommodation. Survey results were tallied and presented as percentages where applicable.

RESULTS AND DISCUSSION:

Demographics

Respondents

The final analysis included respondents from 64 different school districts, 37 from Texas and 27 from Indiana. Of the respondents, 59% were Directors, 11% were Assistant Directors, 25% were Dietitians, and 5% identified as Other.

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Table 1 provides a comparison between the sample of school districts included in the study and the total student population in Texas and Indiana in the 2021–2022 school year. The sample districts displayed variability in demographics, including enrollment size, percentage of ED, racial and ethnic composition, and urban/rural classification. While the districts in the sample reflect a similar overall demographic structure to the student populations in both states, there are some key differences. The sample districts had a higher mean percentage of white students (48.8% vs. 32.6%), a lower percentage of Hispanic students (34.0% vs. 46.4%), and lower ED (51.0% vs 58.4%). The average USDA rural/urban continuum score (1 = most urban, 9 = most rural) for the sample districts was 2.1, indicating that most districts were in highly urbanized areas.

Table 1: *District-Level Sample Characteristics of School Districts Included in the Special Diet Cross-Sectional Study Compared to Total Student Enrollment Demographics in Texas and Indiana for the 2021–2022 School Year*

Variable	Sample: Total, District Mean ± SD[a]	Total Student Enrollment for Texas and Indiana
Enrollment	1146431, 17,913 ± 28,838	6,461,151
% ED[b]	52.8%, 51.0% ± 23.8%	58.4%
% African American	14.5%, 9.6% ± 12.6%	12.8%
% Hispanic	45.2%, 34.0% ± 27%	46.4%
% White	29.3%, 48.8% ± 30.2%	32.6%
% Asian	7.4%, 3.7% ± 5.9%	4.5%
% Other	3.6%, 3.8% ± 2.5%	3.7%
Location: Urban-Rural[c]	2.1 ± 2.0	-

[a] Calculated using available state reports for the 2021–2022 school year (Texas: https://rptsvr1.tea.texas.gov/adhocrpt/adstc.html; Indiana: https://indianagps.doe.in.gov/)

[b] ED= Economically Disadvantaged

[c] Location classification is based on USDA Urban/Rural Continuum Codes, with 1 being the most urban and 9 as the most rural

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Special Diets

A total of 28,110 special diets were reported for an estimated 1,146,431 students in 64 districts. Of the 28,110 special diets reported, 85.6% (24,064) were classified as food allergies. The second most common accommodation category included intolerances (8.6%), followed by metabolic and autoimmune disorders (3.6%), texture modifications (1.3%), energy/nutrient modifications (0.5%), and formula/tube feedings (0.4%). Table 2 includes the total reports in each category and the percentage of schools reporting at least one accommodation in that category. Only two districts (3.1%) reported no special diet accommodations at the time of the survey.

Table 2: *Child Nutrition Professionals Reported Special Diets Accommodated in Their School District*

Type	Total Amount	Districts with One or More (n=64)
Allergies	24,064 (85.1%)	57 (89.1%)
Intolerances	2,413 (8.6%)	49 (76.6%)
Metabolic and Autoimmune Disorders	1,015 (3.6%)	49 (76.6%)
Texture Modifications	363 (1.3%)	33 (51.6%)
Energy/ Nutrient Modifications	146 (0.5%)	22 (34.4%)
Formula/ Tube Feedings	109 (0.4%)	12 (18.8%)
Total	**28,110**	**62 (96.9%)**

Food Allergies

The majority of the 24,064 food allergies were the top nine, as reported in Table 3. Only 7.9% of allergies were classified as "other". Common "other" food allergies were fruits, including strawberries, bananas, pineapples, and oranges; vegetables, such as corn, cucumbers, and carrots; and red meat, beef, pork, and turkey. Additionally, at least three districts listed dyes, cocoa powder, and mustard as allergies they were accommodating.

Table 3: *Child Nutrition Professionals Reported Food Allergies Accommodated in Their School District*

Allergies	Amount
Peanut	5,710
Tree Nut	4,107
Fluid milk	2,515
Egg	2,312
Fish	2,224
Shellfish	1,958
Wheat	1,217
All Dairy	900
Soy	697
Sesame	515
Other[a]	1,909
Total (district n=64)	**24,064**

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Food Intolerances

The most common intolerance was fluid milk (1721), which accounted for more than half of the 2,413 total intolerances. There was an additional category for fluid milk under allergies. The second most reported food intolerance was gluten intolerance (separated from wheat allergy and celiac disease) (488), followed by food dye (147), monosodium glutamate (MSG) (51), and sulfites (1). Five "other" food intolerances included caffeine and nitrates.

Metabolic, Autoimmune, and Other Chronic Disorders

Special diets related to accommodations for metabolic and autoimmune disorders included celiac disease (647), diabetes (314), phenylketonuria (PKU) (16), galactosemia (6), cystic fibrosis (5), and 27 "other" diseases. The "others" included Prader-Willie disease, eosinophilic esophagitis (EOE), renal diets, homocystinuria, and tyrosinemia.

Other Categories

The last three categories comprised 2.2% of the special diets. The majority were texture modifications (363, 1.3%). The most common accommodations related to texture included pureed food (with or without thickening agents) (117), mechanical soft/soft and bite-sized (129), food cut into small pieces (31), student aversions of certain textures (20), temporary diet for students missing multiple teeth (3), and three diets under "other" texture modifications.

Energy and nutrient modifications accounted for only 0.4% (109) of reported special diets. These diet modifications included low carbohydrate (75), low sodium (22), low energy/ calorie (17), high energy/ calorie (14), low fat/ cholesterol (6), decreased protein (4), increased protein (3), and six other modifications.

There were 109 formula or tube-feeding special diets in total. Of those, 68 accommodations included adding supplemental formula to a tray, 32 accommodations included oral or tube-feeding formula only, and nine "other" accommodations.

School Policies and Accommodations

As formal and informal school policies could change the number of special diets reported, the second half of the survey sought to capture the varying policies in the respondents' school districts. The survey queried respondents about policies related to peanuts, milk, and fish. Additionally, respondents were asked a series of yes/no questions about policies and menu options for special diets for non-medical reasons. Sixty-two responses were collected in this section of the survey. Some respondents skipped sections, so the number of respondents ranged from 59 to 62. Survey respondent details are in Table 4.

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Table 4. *District-Level Policies Related to Accommodating Diets*

Question	Yes % (n)	Total (n)
Do you accommodate personal preferences?	19.6% (12)	61
Do you accommodate religious preferences	53.2% (33)	62
Do you provide a vegetarian option daily?	69.4% (43)	62
Do you provide a vegan option daily?	12.9% (8)	62
Do you provide a gluten-free option daily?	25.6% (15)	61
Do you provide a pork-free option daily?	71.0% (44)	62
Do you provide a beef-free option daily?	59.7% (37)	62
Do you provide a kosher option daily?	5.1% (3)	59
During Lent, do you provide meat-free options on Friday?	77.0% (47)	61

Peanuts and Tree Nuts

For peanuts, 48.4% (30) of respondents reported that their schools do not serve peanuts. Eleven of the sixty-two respondents (17.7%) report having peanut-free zones in their district, and three (4.8%) are not allowed to bring peanut-containing items from home. Of the 62 respondents, 24.2% (15) do not serve tree nuts, 12.9% (8) offer a tree-nut-free zone, and 4.8% (3) also report a ban on students allowing tree-nut-containing items from home.

Fish

Eighty-five percent (53) of the respondents serve fish in their districts. Only one respondent has a fish-free zone in their district, and no respondents ban students from bringing fish from home for lunch.

Milk Substitutes

Respondents were asked how they offer milk substitutes to their students. As multiple options could apply, they were encouraged to report all those included in their current process. Of the 61 respondents that indicated at least one milk modification, the most reported were: soy milk is available to students with a diet modification form only (41), lactose-free milk is available to students with a diet modification form only (22), other plant-based milk is available to students with a diet modification form only (12), other policy beyond what is listed here (11), lactose-free milk is available to all students in the cafeteria line (7), soy milk is available to all students in the cafeteria line (5), and other plant-based milk is available to all students in the cafeteria line (1).

Other Accommodations

The survey included questions about accommodations beyond medically necessary special diets. Questions and answers are in Table 4. Overall, 53.2% of respondents reported accommodating religious preference. Specific religious menu patterns such as serving meat-free options on Friday during Lent (77.0%), pork-free options daily (71.0%), beef-free options daily (59.7%), and vegetarian options daily (69.4%) were more common than specific accommodations for religious preference. Accommodating personal preferences was less common (19.6%).

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During Lent, do you provide meat-free options on Friday?	77.0% (47)	61

CONCLUSIONS AND APPLICATIONS:

Our study provided an updated snapshot of special diet accommodations and related policies in child nutrition programs in a sample of districts in Texas and Indiana. Nearly all districts in our sample reported accommodating special diets, mostly related to food allergies. Additionally, districts implement various food-related policies that influence medically necessary and personal, cultural, or religious dietary needs.

Increases in Food Allergies

We found an overall increase in special accommodations compared to a 1994 study in which the authors reported that 46% of child nutrition managers had no children with special diets in their schools (Yadrick & Sneed, 1994). In contrast, our 2022 study, which focused on district-level data, found that only two out of the 64 districts (3.1%) reported no special diet accommodations. This increase was particularly evident in food allergies, with the percentage of districts reporting at least one food allergy rising from 55.6% in 1994 to 89.1% in our study. A study published in 2018 found that 88.0% of their sample reported accommodating at least one food allergy within their school district, which is consistent with our findings (Sauer et al., 2018). This trend may be partially related to the change in guidelines that mandate health-related accommodations but is also likely influenced by the increasing prevalence of food allergies in the US (Gupta et al., 2018; Keet et al., 2014).

Food allergies accounted for 85.1% of the special diet accommodations. Since multiple allergies for a single student were counted separately, the maximum percentage of students with food allergies was estimated at 2%, far below the national estimate of 8% (Gupta et al., 2018). Several factors may explain this discrepancy. First, the mean demographic distribution in our sample reflected a higher proportion of white students and fewer economically disadvantaged students, populations with lower reported rates of food allergy (American Academy of Allergy, Asthma & Immunology, 2025). However, most districts in the sample were located in highly urbanized areas, where food allergies tend to be more common (Sakai-Bizmark et al., 2019). Additionally, parents may only submit special diet forms if their child regularly eats school meals, despite best practices to encourage all students with medically necessary special dietary needs to submit forms to keep in file in case

they do come through the line. Administrative barriers or perceptions of a burdensome process may also reduce form submission. Finally, this study excluded homeschooled children and students in schools not participating in USDA child nutrition programs, which may further limit allergy reporting.

A Call for Policy-Level Guidance for Food Allergy Management

Our findings highlight significant variability in district-level policies for accommodating special diets, particularly in allergen management. This variability is echoed in a study that described interviews with 129 students with food allergies who reported feeling confusion in navigating various policies, some of which were perceived as socially isolating (e.g. allergen free cafeteria zones) (Dupuis et al., 2020). The CDC published voluntary guidelines for managing food allergies in schools 2013 that provide recommendations for food allergies policy management. However, these guidelines are vague in their instructions for whether a district should implement policies like allergen-free zones and allergen bans (Centers for Disease Control and Prevention, 2013; Dupuis et al., 2020).

Policies related to allergens can also affect data tracking. Schools with peanut-free policies may not formally track peanut allergies, as parents may not submit forms when the risk is already mitigated. Additionally, within the comments on the survey, we found that policies may differ within districts, often with more strict policies in elementary schools, which relax in higher grades as students can choose foods that align with their special diet, something the survey design was not able to capture.

Peanut bans were the most reported allergen-related policy in our study at 48.4%. Research offers mixed evidence on the effectiveness of peanut bans. Proponents of the ban argue that young children face exposure risk through non-ingestion contact, and current inadequate emergency policies warrant removing peanuts from schools (Abrams & Watson, 2017a). However, others argue that peanut bans do not reduce the rate of allergic reactions, create a false sense of security, and are not realistic for other common allergens such as milk (Abrams & Watson, 2017b; Portnoy & Shroba, 2014).

Given the growing prevalence of food allergies and inconsistent handling of policies within school districts, there is a critical need for clear federal guidance, such as guidance from the USDA, to establish minimum, evidence-based standards for allergy management for schools that receive federal reimbursement. One of the most recent reviews of food allergy management policies in schools was undertaken to help guide COVID-19 practices and emphasized practical preventive measures rather than allergen bans and provided strategies for allergy management, including reinforcing handwashing, cleaning, and not sharing food (Greenhawt et al., 2020). Some recommendations may not be relevant due to the focus on COVID-19-related feeding needs, and additional data are needed to inform policies for special diets.

The Need for Continued Special Diet Flexibility

Special diets are used to address more than just food allergies, and there will need to be continued flexibility in policies to allow for districts to best meet their populations' cultural, religious, and medical needs. Policies and practices to accommodate special diets often use similar methods for medical and non-medical

accommodations. For example, some districts list pork as an allergen, not because it is a common allergen, but to help families find pork-free options, a proactive adaptation to meet religious needs. Similarly, milk substitute policies vary within and between districts and are often handled at the school level, with some schools requiring diet modification forms and others offering options freely in the cafeteria line.

Limitations

This study has several limitations. The sample was limited to Texas and Indiana, which may affect the generalizability of the findings, especially since district-level policies and practices can vary widely based on state regulations, district size, and demographics. Selection bias may have been introduced through the utilization of voluntary participation, biasing towards districts with more developed resources, more well-connected, or having a stronger focus on special diets may have been more likely to respond. Providing an incentive may have helped reduce selection bias and increase participation.

Counts were based on district-level reports of accommodations rather than individual students, making it difficult to determine how many students were receiving special diets in this sample, which was further compounded by variations in how districts track dietary modifications. The demographic composition of the sample, including representing more districts in urban locations, may have influenced reporting trends, particularly for food allergies. Lastly, the survey was piloted with two food service professionals and modeled after a previous study, but no formal validation was conducted.

Conclusions

Our study highlights the current complexity of accommodating special diets in child nutrition programs and the specialized skills required to manage these accommodations effectively. In acknowledgment of this complexity, in March 2016, the USDA established professional standards for hiring child nutrition directors (Food and Nutrition Service, USDA, 2015). These focus on nutrition and food safety education, with flexibility based on district size. One study found a significant increase in hiring directors with a degree in nutrition or a related field, an RD or RDN credential, and ServSafe or food safety certification from 2012 to 2016 (Merlo et al., 2020). Nutrition professionals and registered dietitians have the necessary education and training to deal with the growing complexity of special diets.

In the districts that participated in this study, many more accommodated special diets than were reported in the literature 30 years ago, and districts accomplished this through various policies. More research, especially a national study on special diets in school districts, would benefit future policy work, training, and research. Additionally, this work could help inform food manufacturers that create specialty products for child nutrition programs. Despite this, more immediate guidance on a federal level on best practices, such as the use of allergen bans, is needed to inform policies and procedures in all federally funded child nutrition programs.

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ABSTRACT

PURPOSE/OBJECTIVES

Special diets are increasingly common in child nutrition programs. However, recent data on the types and frequency of accommodations and policies that districts use to make them are limited. This cross-sectional study aimed to determine the type and number of special diets and current policies and practices for accommodating diets beyond standard meal patterns.

METHODS

An electronic survey was sent to child nutrition professionals in Texas and Indiana in 2022. Participants were recruited through email lists, professional organizations, and snowball sampling. District-level demographics were aggregated from publicly available state databases, and survey responses were tallied by category or question.

RESULTS

Sixty-four child nutrition professionals provided district-level data on 28,110 special diet modifications. Of these modifications, 85.1% were food allergies. All but two (96.9%) of the 64 districts surveyed reported at least one special diet.

There were a variety of policies related to these accommodations, including peanut (e.g., bans, peanut-free zones) and milk substitution policies (e.g., types of milk served, availability, required documentation). Cultural and religious needs were also considered in menu planning, with common accommodations including serving fish on Fridays during Lent (77.0%), pork-free options (71.0%), and vegetarian meals (69.4%). Less common were vegan (12.9%), gluten-free (25.6%), and kosher (5.1%) options.

APPLICATIONS TO CHILD NUTRITION PROFESSIONALS

Our findings underscore the need for clear, evidence-based guidance on food allergy management policies and practices, particularly from the USDA or other federal agencies, to ensure all schools are following the safest practices. Special diets as a whole need to stay flexible to ensure child nutrition professionals can meet the district's personal, cultural, and religious needs. By staying informed about current trends, best practices, and policy updates, child nutrition professionals can create safer and more inclusive meal environments that meet the diverse needs of all students they serve.

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REFERENCES

Abrams, E. M., & Watson, W. (2017a). Should peanuts be allowed in schools? No. Canadian Family Physician, 63(10), 751–752.

Abrams, E. M., & Watson, W. (2017b). Should peanuts be allowed in schools? Yes. Canadian Family Physician, 63(10), 750–751.

American Academy of Allergy, Asthma & Immunology. (2025). Addressing health disparities in food allergy: A Position Statement of the AAAAI Prior Authorization Task Force. *The Journal of Allergy and Clinical Immunology*, *155*(1), 53–61. https://doi.org/10.1016/j.jaci.2024.10.008

Centers for Disease Control and Prevention. (2013). Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs. US Department of Health and Human Services.

Dupuis, R., Kinsey, E. W., Spergel, J. M., Brown-Whitehorn, T., Graves, A., Samuelson, K., Epstein, C., Mollen, C., & Cannuscio, C. C. (2020). Food allergy management at school. *The Journal of School Health*, *90*(5), 395–406. https://doi.org/10.1111/josh.12885

Greenhawt, M., Shaker, M., Stukus, D. R., Fleischer, D. M., Hourihane, J., Tang, M. L. K., Abrams, E. M., Wang, J., Bingemann, T. A., Chan, E. S., Lieberman, J., Sampson, H. A., Bock, S. A., Young, M. C., Waserman, S., & Mack, D. P. (2020). Managing Food Allergy in Schools During the COVID-19 Pandemic. *The Journal of Allergy and Clinical Immunology. In Practice*, *8*(9), 2845–2850. https://doi.org/10.1016/j.jaip.2020.07.016

Gupta, R. S., Warren, C. M., Smith, B. M., Blumenstock, J. A., Jiang, J., Davis, M. M., & Nadeau, K. C. (2018). The Public Health Impact of Parent-Reported Childhood Food Allergies in the United States. *Pediatrics*, *142*(6). https://doi.org/10.1542/peds.2018-1235

Keet, C. A., Savage, J. H., Seopaul, S., Peng, R. D., Wood, R. A., & Matsui, E. C. (2014). Temporal trends and racial/ethnic disparity in self-reported pediatric food allergy in the United States. *Annals of Allergy, Asthma & Immunology*, *112*(3), 222-229.e3. https://doi.org/10.1016/j.anai.2013.12.007

Portnoy, J. M., & Shroba, J. (2014). Managing food allergies in schools. *Current Allergy and Asthma Reports*, *14*(10), 467. https://doi.org/10.1007/s11882-014-0467-z

Sakai-Bizmark, R., Friedlander, S. M. I., Oshima, K., Webber, E. J., Mena, L. A., Marr, E. H., & Ohtsuka, Y. (2019). Urban/rural residence effect on emergency department visits arising from food-induced anaphylaxis. *Allergology International*, *68*(3), 316–320. https://doi.org/10.1016/j.alit.2018.12.007

US Department of Agriculture Food and Nutrition Service. (2017, July 25). *Accommodating Children With Disabilities in the School Meal Programs: Guidance for School Food Service Professionals*. http://fns-prod.azureedge.us/sites/default/files/cn/SP40-2017a1.pdf

US Department of Education, Office of Civil Rights. (2010, August). Free Appropriate Public Education for Students With Disabilities: Requirements Under Section 504 of the Rehabilitation Act of 1973. https://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html

Yadrick, K., & Sneed, J. (1994). Nutrition services for children with developmental disabilities and chronic illnesses in education programs. *Journal of the American Dietetic Association*, *94*(10), 1122–1128. https://doi.org/10.1016/0002-8223(94)91131-2