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In This Issue

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Articles about successful programs, research interventions, evaluations and treatment strategies, meeting announcements and information about educational programs are welcome and should be sent to the editor by the next deadline.

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COOKING IN CLASSROOMS: A POTENTIAL FOOD SAFETY RISK?

Donna W. Lockner, PhD, RD, Ruth Luckasson, JD

Objectives:

1. Identify potential liability and risk of foodborne illness when food preparation is used as a special education classroom activity.
2. Recognize key food safety practices that special education teachers need to know if they are preparing food in the classroom.
3. Acknowledge that nutrition professionals can be advocates for safe food preparation activities in special education classrooms.

INTRODUCTION

Cooking in the classroom is an important tool for conveying nutrition education (1,2). Students gain familiarity with foods and practice cooking skills that may help them practice more healthful dietary habits now and in the future. Many teachers also use cooking in the classroom as a tool for demonstrating more abstract concepts of science and mathematics and for integrating multicultural experiences into the curriculum. Cooking is a very common activity for special education classes because many students with disabilities need concrete examples of concepts they are learning and it enables them to practice functional life skills. Also, food preparation in special education classrooms may be used for fundraising to support community instruction and field trips.

When food is prepared in a classroom setting there are frequently many individuals handling the food. Utensils and often refrigeration, cooking, and cleaning equipment may be limited. Therefore, teachers need to be vigilant of food safety practices to ensure that cooking in the classroom does not promote foodborne illness among students and staff. Special education teachers, in particular, should be knowledgeable about food safety because children with disabilities often have physical manifestations associated with developmental delays that place them at elevated risk for infection (3-5).

Foodborne illness is common in the United States with estimates of 76 million cases per year and 325,000 hospitalizations per year (6). Due to these epidemic proportions, the Food and Drug Administration and Food Safety and Inspection Service of the United States Department of Agriculture have targeted food safety as a major focus in Healthy People 2010 (7) hoping to reduce the incidence of foodborne illness markedly in the coming years. Despite a decline in the reported incidence of several bacterial foodborne infections in 2001, a further reduction is needed to meet the objectives of Healthy People 2010 (8) and reduce the symptoms and side effects of foodborne illness. For most healthy adults, the symptoms may range from mild nausea to more severe vomiting and diarrhea, but for susceptible individuals such as children, the elderly, and

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From the Chair

Susan S. Zabriskie, RD, MS

Have you ever heard the story of the eighteenth camel? An old man living in a village of some ancient desert locale died, leaving his sole personal assets, seventeen camels, to his three sons. His will included instructions on disbursement of the camels: the first son was to get half the camels, the second son a third of the camels and the third son one ninth of the herd. Many wise men and mathematicians were consulted to find a way to accomplish this, but to no avail. Finally, a neighbor came to them with a solution: Take one of my camels. You will then have 18. The first son will get nine camels. The second of you will take six camels. The third will get two camels. That leaves one camel, which you can return to me.

I think of our work as DDPD EXECUTIVE COMMITTEE MEMBERS as the eighteenth camel. The work of a dietetic practice group within our profession is a continuous process-publications such as our Pocket guide were the collective work of several generations of active members. This excellent newsletter is sent in a seamless quarterly mailing though editors change every 2 years. Our finances are accounted for, our Web site will be updated, our membership mailings all continue through many changes of command. I am delighted to have been a part of this process. The ADA is an impressive professional organization and our own dietetic practice group is an extension of its thoroughness and ethical and professional standards. Individual members brought these standards into existence and perpetuate its mission. I urge all of you who read this publication to become actively involved in our dietetic practice group. Each of us can make a difference in the lives of a few. But together, as one voice we can effect social and political change far greater than we can imagine. The Medical Nutrition Therapy Bill is one such example. Your voices will be heard and respected. Whether you express a concern, request a change, create a tool for instruction or share your insights on clinical practice, there's a good chance that it would benefit many of our members and the people they serve.

Since this is my last letter as DDPD chair, I would like to acknowledge the gracious efforts of our executive committee members for 2003-2004:

Thank you to Melissa, our outstanding newsletter editor, she has been the model of grace under pressure, no small task for that job!

Thank you to Lee, who has kept tabs on our finances most cheerfully and carefully, she could easily switch careers to the accounting world!

Thank you to Lynn, a wonderful and wise Web master. Her many years of service to the dietetic practice group served all of us well in creating and updating our DDPD web site. The listserv she set up this year has been a valuable network for information exchange and dialogue among our members.

Thank you to Roz, both for her meticulous work as membership chair and for being excellent company at the past three FNCE meetings!

Thank you to MaryEllen and RuthAnn as past chairs. Their wisdom and experience were essential in every board action and decision.

Thank you to Ann Hatcher, Karen Blachley, Ann Overmeyer, and Joyce Lowe—our resource professionals and librarian, whose behind the scenes efforts provide much needed information to our members throughout the year.

Thank you to Daria for keeping us updated and aware of the legislative issues that relate to our profession.

Mary Emerson has already done a great job as chair-elect and comes to us with a wealth of experience in state dietetic association activities. Please welcome her as DDPD chair with your support and participation!

Kim Hanigan (ADA Practice Team Liaison), Susan Zabriskie, Chair, and Mary Emerson, Chair-Elect at the ADA Leadership Institute held this February in Arizona.

individuals with compromised immune function, the effects of foodborne illness can be much more severe. Hemolytic uremic syndrome is seen in up to 7% of children who contract foodborne illness due to *Escherichia coli* O157:H7 (9) and is the leading cause of kidney failure in children (10). Guillain-Barre Syndrome, which can lead to paralysis in both children and adults due to nerve damage, has been linked to recent foodborne infection with *Campylobacter* (11). Reactive arthritis is also linked to common foodborne pathogens such as *Salmonella, Shigella, and Campylobacter* (12). In addition, foodborne illness can be fatal; it is estimated that 5,000 deaths attributed to foodborne illness occur per year in the United States (6). With these risks, it is essential that food safety be emphasized when food is prepared in the classroom.

Assessment of teachers' knowledge about foodborne illness and food safety is limited, but high school science teachers were recently shown to have gaps in their knowledge of food safety (13). In addition, a national survey found the majority of schools did not require new teachers to have training in health education, where food safety information would likely be addressed (14). Food safety knowledge of consumers has also been shown to be poor (15,16). Given these reports, it is likely that many teachers may be lacking in food safety knowledge needed if cooking in the classroom is practiced. Therefore, the purpose of the survey reported here was to identify the extent of food preparation in secondary public school special education classrooms and the food safety knowledge of special education teachers. Special education teachers were targeted in this survey because of the heightened risk of foodborne illness for students with disabilities and associated chronic medical conditions.

METHODS

Since no appropriate instrument to assess teachers' knowledge of basic food safety was identified, a survey was drafted specifically for this study. The survey was based primarily on consumer behaviors identified by Medeiros et al. (17) as factors related to the most common foodborne illnesses and to the illnesses with the most serious consequences. A panel of environmental health department food safety officers, nutrition professionals, and special education university faculty reviewed the survey for content validity. Pilot testing of the instrument was done with special education teachers who were also enrolled in a graduate course at the local university. In the final phase of survey revision and pilot-testing, 13 special education teachers completed the survey to ensure that the response burden was minimized and the survey could be completed in less than 10 minutes.

Teachers' ability to identify potentially hazardous foods was tested with a list of 17 foods, while ability to recognize practices that would reduce risk of foodborne illness was tested with a list of 12 possible practices. Other questions related to proper cooking, holding and storage temperatures to minimize risk and amount of time that potentially hazardous foods could be safely kept at room temperature. Most questions allowed multiple responses and teachers were instructed to check all that applied. If there was only one correct answer teachers were instructed to check only one response. Open-ended questions followed the multiple choice questions to identify teachers' training in food safety, frequency of using food preparation in the classroom, and type of foods prepared.

The survey was mailed to special education teachers (n=906) in a large metropolitan public school district. Teachers were advised of the purpose of the survey and guaranteed anonymity in the cover letter. Each survey was coded to track response, but coding was removed before the responses were read and compiled so teachers could answer honestly without fear of having their responses tracked to their school or classroom. Reminder postcards were sent if responses were not received within one month.

Descriptive frequency distribution statistics were compiled using SPSS version 10.1 for windows (SPSS Inc., Chicago, IL). Chi square analysis was used to compare food safety knowledge of teachers who prepare food in the classroom to those who reported never cooking in the classroom and to compare past training in food safety with current food safety knowledge. Significance was set at $p<.05$.

The Institutional Review Boards of the sponsoring university and public school district approved this study.

Table 1. Percent of respondents who correctly indicated the food was likely to cause food poisoning if not handled properly. (n=228)

Percent of Respondents	Identified Food
98.7	Raw meat
98.7	Raw poultry
98.0	Raw eggs
96.7	Raw fish
77.2	Unpasteurized juice
72.4	Milk and cheese
65.8	Cooked poultry
64.5	Cooked meat
61.8	Cooked fish
53.5	Cooked eggs
35.5	Cooked beans (such as pinto and navy)

RESULTS

A total of 255 surveys (28.1%) were returned, with 27 not filled out because the teachers indicated they were no longer in the classroom setting. This left 228 usable responses. Expressed as a percentage of respondents, 54% of special education teachers use food preparation as part of classroom activities. Of those who use food preparation, 43.3% do so at least once per month and 17.5% do so at least once per week. Teachers' ability to identify potentially hazardous foods is provided in Table 1. Most teachers (95.2%) correctly reported a thermometer was the best method to determine the temperature of food, while fewer knew the correct temperature for storing foods (56.5%) or holding hot foods (44.3%). Teachers' knowledge of other practices that reduce food-borne illness is shown in Table 2.

Table 2. Percent of respondents who correctly indicated the practice would reduce the risk of food poisoning. (n=228)

Percent of Respondents	Identified practice
98.7	Clean utensils and food preparation surfaces after contact with raw meat or poultry
92.6	Wash hands after visiting bathroom or changing diapers
88.6	Wash hands after touching animals
76.4	Wash hands after touching face
74.2	Wear disposable plastic gloves if you have a cut on your hands
59.4	Do not prepare food for others if you have diarrhea
59.0	Drink only pasteurized milk or juices
26.2	Avoid eating raw sprouts

In response to the open-ended question about foods prepared in the classroom during the past 2 years, the most commonly named food was cookies (listed by 66 teachers) with meat being the second-most commonly cooked (listed by 46 teachers). Potentially hazardous foods such as meat, eggs, milk products, and beans were listed as prepared in the classroom during the past 2 years by 76.8% of teachers who use classroom cooking activities.

Most teachers (72.2%) reported never receiving any training in food safety. For those who have had some training, the source most often cited was as part of a foodservice industry job (40.3%).

Results of the chi square analysis indicated there was no significant difference in food safety knowledge between teachers who use food preparation in the classroom and those who do not ($p>.05$). Likewise, teachers who reported food safety training in the past showed no difference in food safety knowledge compared to those who had never received training ($p>.05$).

DISCUSSION

The results of this study indicate that the majority of the special education teachers responding to this survey are using food preparation as a component of their classroom activities. Although the educational benefits of participating in such activities are recognized, foodborne illness is a threat whenever potentially hazardous foods are used. The types of food teachers report preparing include meat, eggs, and beans, which are potentially hazardous.

Almost all teachers indicated they knew raw meat, fish, poultry, and eggs were potentially hazardous, but close to a third of the teachers did not recognize that cooked meat, fish, poultry, and eggs still are potentially hazardous and thus require special handling. These foods are often used when the product will be consumed as a meal. If the food is prepared much earlier than mealtime, there may be considerable delay in serving, with the risk of foodborne illness increasing exponentially over time. Beans, often used in burritos and with other Mexican foods, are commonly cooked in the city where this survey was conducted. Due to their high moisture and protein content, beans are an excellent medium for growth of pathogenic bacteria, however, only 35.5% of the teachers knew beans are a potentially hazardous food.
Unpasteurized juice has been reported as the cause of illness in at least 15 outbreaks (18), yet 22.8% of respondents did not indicate they knew unpasteurized juice could cause foodborne illness. Even if juice is not used in functional cooking activities, it may be brought into the classroom as a snack beverage or incorporated in teaching activities such as learning to express choices and teachers need to be aware of possible risks.

Most teachers were aware of some common practices that reduce risk of foodborne illness, but for some practices, such as hand washing, it is alarming that not all teachers reported awareness of the importance. Although 92.6% of teachers indicated that washing hands after using the bathroom or changing diapers would reduce risk, the fact that 7.4% of respondents did not indicate that they realized the practice would reduce foodborne illness is dramatic. Since some special education teachers frequently change diapers, especially those serving students with severe disabilities, it is extremely important they recognize the danger in handling food without proper hand washing. Foodborne illness caused by human fecal pathogens such as hepatitis A, Norwalk-like viruses, and *Shigella*

species account for a significant number of cases of all foodborne illness (17), and therefore vigilant personal hygiene can be very effective in reducing many cases of foodborne illness. The human face harbors pathogens such as *Staphylococcus* and animals may carry *Salmonella* and *Campylobacter* that can be transferred to food by hands. Almost one quarter of teachers did not indicate that washing hands after touching the face would reduce risk, while 11.4% did not think washing hands after touching animals was related to risk of foodborne illness.

Raw sprouts, once thought to be a healthful addition to the diet, have lately been shown to frequently be contaminated with *Salmonella* and *E. coli* (19) and FDA has warned consumers to avoid raw alfalfa and clover sprouts (20). Educational campaigns to make the public aware of this recommendation have not reached a wide audience among teachers, as evidenced by only 26.2% of teachers recognizing that avoiding raw sprouts will reduce risk of foodborne illness.

If teachers were aware of a lack of knowledge about food safety, it is possible that they may avoid using food preparation in the classroom as a teaching tool. Although teachers' perception of their own knowledge was not addressed in this survey, teachers who were more knowledgeable about food safety practices did not report any difference in the frequency of food preparation than those who were less knowledgeable. This is cause for concern since it appears that teachers do not consider whether they are qualified to be safely handling potentially hazardous foods with children who may be at increased risk for foodborne illness. Just as teachers are expected to meet certain levels of competencies in content areas before they engage in classroom instruction, competency in safe food handling practices should be assured before teachers are allowed to expose students to potential risk.

School administrators may not be currently aware of the risk to students and staff and potential liability if lack of food safety knowledge leads to foodborne illness in their school. Although it is important for administrators to recognize the problem, it should be made clear to them that limiting or prohibiting functional cooking activities in the classrooms, especially special education classrooms is not a good solution. Cooking in the classroom and learning safe food preparation practices is an important part of nutrition education and the whole educational process for students with developmental delays. This functional activity provides concrete life skills which, when mastered, will enable students to participate more fully in activities of daily living (21). Therefore, in order for classroom cooking activities to be continued with a minimum of risk, teachers need training on appropriate food safety practices.

Although only a small percentage of teachers reported previous training in food safety, it is surprising that those who had training were not more knowledgeable on food safety practices than those who reported no previous training. It is possible that the training, usually acquired as part of a food service job, was not relevant enough to food preparation in the classroom so transfer of knowledge did not occur for these teachers. If the ultimate goal is to ensure the health of students as well as staff, the training needs to be effective in providing information that the teachers will put into practice. The training should be easily accessible, not overly time consuming, and provided in a variety of formats to accommodate differing adult learning styles. Nutrition professionals, with their knowledge of food safety and nutrition education curricula, are an excellent resource for school districts to help plan and implement food safety training for teachers.

Limitations of this study include the bias that those teachers who responded to the survey may be those more interested in food preparation or food safety and may not represent the views of special education teachers or other teachers in general. Also, knowledge of food safety may not correspond with behaviors practiced during food preparation. Either of these circumstances would make the actual risk that students are exposed to higher than what is already reported here. In addition, a higher response rate to the survey would improve the generalizability of these results, but the time constrains of public school teachers limits their participation in most surveys.

IMPLICATIONS FOR PRACTICE

As nutrition professionals encourage cooking in the classroom, it is important the teachers be given information and strategies to protect the health of students, faculty and staff. Food safety training provided to teachers in a format that is quick and easy to use will help to ensure the health of students and decrease liability for school districts if children are exposed to foodborne illness. Longer-term benefits for the students include life skills for the future. Teachers can model behavior and prepare students to make appropriate food choices and engage in recommended food safety practices that will promote health for themselves and their future families.

Donna Lockner is an assistant professor of individual, family, and community education at the the University of New Mexico.

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Continuing Professional Education

Questionnaire for RD's and DTR's

This self-study program is available only to members of Dietetics in Developmental and Psychiatric Disorders.

After reading the continuing professional education article "**Cooking in Classrooms, a Potential Food Safety Risk?**" please answer the following questions by indicating your responses on the Continuing Education Reporting form on page 7.This activity has been approved for 1 hour of continuing professional education credit for registered dietitians and dietetic technicians, registered, by the Commission on Dietetic Registration.

1. Which is correct about foodborne illnesses in 2001?
   a. The incidence of all foodborne illnesses continued to increase.
   b. The incidence of some bacterial foodborne illnesses decreased.
   c. The incidence of some viral foodborne illnesses decreased.
   d. The incidence of all foodborne illnesses decreased.
2. Which organism can lead to hemolytic uremic syndrome and kidney failure in children?
   a. Campylobatcer
   b. Salmonella
   c. Shigella
   d. Escherichia coli 0157:H7
3. According to the authors, which is an important purpose of cooking in classrooms for children with developmental delays?
   a. Add to nutritional intake.
   b. Provide concrete life skills.
   c. Decrease labor costs in the schools' foodservice department.
   d. Minimize the need for packed lunches.
4. From the survey conducted, which statement is correct regarding the food safety knowledge of special education teachers?
   a. Those who use food preparation in the classroom showed improved food safety knowledge.
   b. Previous food safety training was positively associated with improved food safety knowledge.
   c. Teachers with over 10 years experience scored higher on the food safety test.
   d. There was no association found between previous food safety training and food safety knowledge
5. Which of the following food safety practices were the special education teachers least likely to be aware of?
   a. Persons with diarrhea should avoid handling food
   b. Hands should be washed hands after touching animals.
   c. Cover a cut on hands with plastic gloves
   d. Use a thermometer to check food temperatures
6. Why is food safety a concern in special education classrooms?
   a. The room temperature must be kept warm.
   b. Gloves may not be worn due to latex allergies
   c. Steamtables must be kept at low settings to prevent burns.
   d. Many students may be handling food.
7. How many of the teachers in this study prepared potentially hazardous food in the classroom during the last 2 years?
   a. 5%
   b. 36%
   c. 52%
   d. 77%
8. According to the authors, how should school administrators manage the risk of foodborne illness from cooking in the classroom?
   a. Cooking should not be permitted
   b. Avoid all raw foods
   c. Educate teachers and students about safe food handling practices
   d. Have foodservice staff members take over any food-related tasks

Continuing Professional Education Reporting Form

Developmental Issues articles: **"Cooking in Classrooms, a Potential Food Safety Risk?";** Spring, 2004.

This activity has been approved for 1 hour of continuing professional education credit for registered dietitians and dietetic technicians, registered. If you would like to receive a completion certificate please see below.

You must be a member of the DDPD to participate. This CPE activity is free of charge.

Expiration deadline: Postmarked December 31, 2004

❑ PDP ❑ non-PDP *(PDP = Professional Development Portfolio)*

❑ I do NOT need a completion certificate

❑ Please send a completion certificate by email to the following address: _____

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For questions email: Mary Ellen Posthauer, RD, CD, LD at MEPRDCD@aol.com

After reading each statement please select the best answer:

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D
6. A B C D
7. A B C D
8. A B C D

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You may want to look into these opportunities:

www.rossce.com Ross sponsors several on-line programs related to enteral feeding and oral supplement ingredients and health.

www.bellinstitute.com/calcium This site is sponsored by General Mills and includes a 2 hour program reviewing the new research about calcium and weight management.

http://www.dga2000training.usda.gov. The program about the Dietary Guidelines is worth 5 CEUs.

International Congress of Dietetics

Chicago, IL May 28-31, 2004

DDPD is providing a speaker stipend for DDPD member Jocelyn Rodriques, RD to speak about Nourishing the HIV and Hepatitis C Co-infected Drug Abuser within the session "The Nutrition Component of Substance Abuse Programs."

DDPD Election Results

Chair-elect: Lee Wallace

Secretary-Treasurer: Cherry Chanley

Nominating chair: Roz Wilkins

Thank you to everyone who voted!

From the Editor

Melissa Altman-Traub MS, RD, LDN

As our group continues to grow with the energy of new members, we invite those of you who are interested in helping with any ongoing projects to contact the executive committee members. We are happy to announce an opening for an assistant newsletter editor. This individual will assist the editor in coordinating the quarterly DevelopMental Issues, and will move into the editor position in the spring of 2005. This would be a great match for you if you enjoy editing and writing and would like the opportunity to shape our most valued member service.

If you are interested, please contact me at Nutrisolutions@aol.com, for more information. Include "DDPD" in the subject line.

If you have expertise with nutrition and substance abuse and would like an opportunity to become a resource professional, please contact Mary Emerson, chair elect, at 207-761-2378 or via e-mail: emersonm@springharbor.org.

Eating Disorders Web sites

Jessica Setnick, MS, RD/LD

Organizations for Eating Disorder Professionals:

Academy for Eating Disorders - **www.aedweb.org**

International Association of Eating Disorders Professionals - **www.iaedp.com**

Educational Web sites for the Public:

National Association of Anorexia Nervosa and Associated Disorders - **www.anad.org**

National Eating Disorders Association - **www.nationaleatingdisorders.org**

Eating Disorders Anonymous - **www.eatingdisordersanonymous.org**

National Institute of Mental Health anorexia study - **www.angenetics.org**

Something Fishy - **www.somethingfishy.org**

Mirror Mirror - **www.mirror-mirror.org**

National Eating Disorder Screening Program - **www.mentalhealthscreening.org**

Gurze Books - **www.bulimia.com**

Eating Disorder Referral and Information Center - **www.edreferral.com**

Psychiatric Medication Update

Mary Emerson, RD

Strattera or Atomoxetine, is the first non-stimulant Attention Deficit/Hyperactivity Disorder (ADHD) medication. Ritalin and Concerta are both formulated with the active ingredient methylphenidate. Ritalin is short acting and can be administered in four hour intervals up to three times per day. Ritalin SR lasts approximately 5-6 hours. Concerta is an extended release formula of methylphenidate and lasts up to 12 hours. Dexedrine (dextroamphetamine) is a stimulant medication commonly used with ADHD. Adderall is the longer lasting form of Dexedrine and commonly prescribed once per day. The dietetic professional's concern with stimulant medication is in diminishing appetite and negatively affecting growth. Stimulant medication should be given after meals to minimize the appetite suppressant effect. Snacks play an important role for all children, but particularly so for children on stimulant medications. A high calorie evening snack can often provide as many calories as mealtimes. Strattera is a selective norepinephrine reuptake inhibitor, a class of ADHD treatment that works differently from the other ADHD medications available. Strattera can be taken once or twice a day. Since Strattera is not a stimulant it is not classified as a controlled substance and can be phoned in for prescriptions and refills. Stimulant drugs can be abused by crushing and snorting, however if Strattera was crushed and snorted it would only hurt the person's nasal passages and not produce the desired high. In short-term clinical trials with children and adolescents, a modest decrease in appetite was the most common side effect. Some children may experience a loss of weight when starting treatment with Strattera. So far the clinical trials show a lower impact on growth with Strattera than with children using traditional stimulant therapy. As with all ADHD medications, growth should be monitored during treatment.

Another new psychiatric medication from Eli Lilley is Symbyax, which is approved for treating bipolar depression. Symbyax is a combination of the antipsychotic Zyprexa (olanzapine) and the antidepressant Prozac (fluxetine hydrochloride) in one capsule. The side effects of Symbyax include weight gain, diarrhea, dry mouth, increased appetite, feeling weak, swelling of the hands and feet, tremor, sore throat, and trouble concentrating. The role of weight management and healthy lifestyle needs to be discussed with the client early in the course of treatment to ensure medication compliance and minimize any weight gain. All atypical antipsychotics (Zyprexa, Risperdal, Clozaril, Seroquel, Geodon. and Abilify) now have a label warning of increased risk of Type II Diabetes. All clients on these medications should have their blood sugars monitored routinely.

Zyprexa Zydis is the orally administered tablet that disintegrates in the mouth. Zydis forms of medication can be taken with or without water and are administered when medication compliance is questioned.

LIVING WELL WITH A DISABILITY

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"**LIVING WELL WITH A DISABILITY: An Update**", at:

http://rtc.ruralinstitute.umt.edu/health/LivingWell.htm

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We salute your career achievements on contributions to our field!

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The Dietetics in Developmental and Psychiatric Disorders Dietetic Practice Group accepts advertisements for our newsletter, *DevelopMental Issues*, under these guidelines:

- Advertisements will be limited to products and services that are of interest to our members, consistent with the goals for the dietetic practice group, and which promote sound nutrition of the patients we serve.

We reserve the right to evaluate all statements in advertisements and to refuse to accept any copy that does not follow guidelines established through the American Dietetic Association.

We require the following disclaimer in each issue of the newsletter: "The publication of an advertisement in *DevelopMental Issues* should not be construed as an endorsement of the advertiser or the product by the American Dietetic Association or this dietetic practice group.

Rates: $2500 to sponsor an entire issue (which includes recognition at our Annual Meeting, a full page ad, a recognition notice, and one year complimentary subscription)

$ 500 for a full page
$ 350 for a half page ad
$ 250 for a quarter page
$ 125 for an eighth page (business card size)
Dietetic Practice Group members are entitled to a 20% discount.

Advertisements may be submitted any time and advertisers will receive notification of acceptance within 30 days of submission, at which time scheduling for placement will be arranged.

Advertisements must be received in camera-ready form by the designated deadline for publication along with payment in full made payable to The American Dietetic Association/DPG #12 and sent to: Melissa Altman-Traub, Newsletter Editor, Nutrisolutions@ aol.com, 1997 Turkey Trot Road, Jamison, PA 18929. Phone: 215/491-5408.

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Resource Professionals

Do you have a professional question you need help with? Contact the appropriate Resource Professional today!

Eating Disorders Resource Professional (00-03)
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Rancho Mirage, CA 92270
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hatchera@mscd.edu

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