

Special Dietary Needs Medical Statement

This school/facility participates in a federally funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability or impairment. If you are requesting a meal accommodation or substitution, please complete and sign this form. A physician note or statement may be required. If you have any questions, please contact _____ at _____.

Parent/Guardian:

Student's Name	Date of Birth	Grade Level/Classroom	Name of School/Site
Name of Parent/Guardian		Phone Number of Parent/Guardian	
Please provide an explanation below of how the student's physical or mental impairment restricts the student's diet.			
Allergies and Intolerances	What food(s)/type(s) of foods should be omitted? Please be as specific as possible.		
	List foods to be substituted.		
Signature of Parent/Guardian		Date	

Medical Authority:

Texture Modifications	The child requires foods be: <input type="checkbox"/> Pureed <input type="checkbox"/> Diced/Finely Ground <input type="checkbox"/> Chopped/cut into bite-size pieces <input type="checkbox"/> Other (please specify): _____	Liquids should be: <input type="checkbox"/> Pudding Thick <input type="checkbox"/> Honey/Nectar Thick <input type="checkbox"/> Thinned <input type="checkbox"/> Other (please specify): _____
Adaptive Eating	Provide an explanation of how the student's physical or mental impairment restricts the student's diet	
Additional Information	Describe any additional details for clarification such as required special adaptive equipment:	
Name of Physician/Medical Authority & Title (please PRINT)		Provider Phone Number
Signature of Physician/Medical Authority		Date

Signing the following section is optional, but may prevent delays by allowing school personnel to speak with the medical authority.

Health Insurance Portability and Accountability Act Waiver (HIPPA)

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (school/program), and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the SCHOOL PROGRAM as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent/guardian/or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: _____ **Date:** _____

School/Faculty Use Only:

- | | |
|---|---|
| <input type="checkbox"/> Form Received on _____. | <input type="checkbox"/> Accommodation will begin on _____. |
| <input type="checkbox"/> Accommodations within meal pattern. | <input type="checkbox"/> Accommodations not within meal pattern. |
| <input type="checkbox"/> Form incomplete. Parent contacted on _____. | |
| <input type="checkbox"/> Form complete. Accommodation will not be made. | <input type="checkbox"/> Request not reasonable. <input type="checkbox"/> 504 coordinator contacted |

_____ Date

_____ Signature of Food Service Director/Contact