Special Dietary Needs Form

Carmel Clay School participates in a federally funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations will be made when the accommodation requested is due to a disability or impairment.
If you are requesting a meal accommodation or substitution for your student, please complete and sign this form.
A physician note or statement may be required if the meal accommodations cannot be met with regularly served menu items.

PARENT/GUARDIAN

Student 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 allergy, disability or physical/mental impairment restricts the student's diet.			
Allergies And Intolerances	Does the student have a life threatening food allergy? ☐ YES ☐ NO If YES, please specify : ***IF THE STUDENT HAS A LIFE THREATENING ALLERGY, PLEASE ALSO FILL OUT AN "ALLERGY ACTION PLAN" FORM**		
	Does the student wish to eat school meals? ☐ YES ☐ NO ☐ SOMETIMES		
	What food(s)/type(s) of foods should be omitted and/or made accommodations for? Please be as specific as possible.		
Signature of Parent/Guardian			Date

MEDICAL AUTHORITY (if required)

Texture Modifications	Please specify if the student needs texture modified foods or beverages (i.e. pureed, chopped, nectar/honey thickened liquids):
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 Carmel Clay Food Services, 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 Carmel Clay School Food Services Department 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 at the end of each school year. 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: ______________________________