OSSEO AREA SCHOOLS

ISD 279

SPECIAL DIET STATEMENT

Please attach a copy of your student's lunch menu for the physician to review.

PART 1: STUDENT INFORMATION - PARENT OR GUARDIAN MUST COMPLETE - PLEASE PRINT

Student LAST Name:	Student FIRST Name:	Student Middle Initial:	Student Date of Birth:
Parent/Guardian Name:	Home Phone:	Work Phone:	Mobil/Cell Phone:
Name of School Student Attends:		Grade Level:	Date::

PART 2: DIETARY ACCOMMODATION—Food to be allowed and Food to be omitted - THIS SECTION MUST BE COMPLETED BY THE LICENSED PHYSICIAN SIGNING THIS FORM

This section must be complete to accommodate any requests. If any information is missing, someone from the district foodservice office will follow up with a parent or physician as needed.

1. State the allergen or food to be avoided:_____
2. Brief explanation of how exposure to this food affects the participant:_____
   _____
3. List specific foods to be omitted and substituted. Attach a sheets with additional instructions as needed.

FOODS TO BE OMITTED	FOODS TO BE SUBSTITUTED

Signature

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document.

Prescribing Authority Credentials (print)_____ Date_____

Signature_____ Clinic/ Hospital_____

Phone Number_____ Fax Number_____

Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other:_____

☐ Tube Feeding Formula Name: _____

Administering Instructions: _____

☐ Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

Other Dietary Modification Or Additional Instructions (describe): _____

Revised: February 11, 2020

Voluntary Authorization

Note to Parent(s)/ Guardian(s)/ Participant: You may authorize the director of the school/ center/ site to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____(physician/medical authority name) to release such protected health information as is necessary for the specific purpose of Special Diet information to _____(program name) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the 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 me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. **Optional:** 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 authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian: _____Date: _____

OR Participant's Signature (Adult Day Care): _____

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Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410

(2) (2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

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