

# Special Dietary Needs Medical Statement Form

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 note from a medical authority 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	
<b>Disability/Medical Need of Student:</b> Allergy _____ Texture Modification _____ Intolerance _____ Other _____			
<u>Allergies</u> and <u>Intolerances</u>	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	

Please obtain a doctor (DO or MD), nurse practitioner (NP), or physician assistant (PA) signature if your student requires a special menu or meal modification.

## Medical Authority:

<u>Texture</u> <u>Modifications</u>	<b>Food should be:</b> Pureed Diced/Finely Ground Chopped/cut into bite-size pieces Other (please specify): _____	<b>Liquids should be:</b> Pudding Thick Honey/Nectar Thick Thinned Other (please specify): _____
<u>Additional</u> <u>Information</u>	Provide an explanation of how the student's physical or mental impairment restricts the student's diet	
	Describe any additional details for clarification such as required special adaptive equipment, reactions to allergies, etc.:	
Name of Medical Authority & Title (please PRINT)		Provider Phone Number
Signature of 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 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. 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 child listed on this document and has the legal authority to sign on behalf of that child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### School/Faculty Use Only:

- ☐ Form Received on \_\_\_\_\_. ☐ Accommodation will begin on \_\_\_\_\_.  
☐ Accommodations within meal pattern. ☐ Accommodations not within meal pattern.  
☐ Form incomplete. Parent contacted on \_\_\_\_\_.  
☐ Form complete. Accommodation will not be made. ☐ Request not reasonable. ☐ 504 coordinator contacted.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Food Service Director/Contact