



Medical Statement for Children *with* Disabilities

Requiring Special Meals in the U.S. Department of Agriculture Child Nutrition Programs

(National School Lunch Program, School Breakfast Program, Afterschool Snack Program, Summer Food Service Program)

This statement must be completed in its entirety and submitted to the school before any meal substitutions can be made for children with disabilities. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's state licensed healthcare provider (updated to include nurse practitioner, physician's assistant, registered dietitian and mental health provider).

Part 1 – To be completed by parent/guardian. Please print.

Child's Name: _____ Birth Date: _____ Male Female

Parent/Guardian's Name: _____

Work Phone: (____) _____ Home Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Educational Rights and Privacy Act (FERPA) I hereby authorize

(Name of Licensed Provider)

to release such protected health information of my child as is necessary for the specific purpose of special diet information to

(Name of School)

and I consent to allow the provider to freely exchange the information listed on this form and in my child's records with the school district 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 I may rescind permission to release this information at any time except when the information has already been released. My permission to release this information will expire on _____. (*Expiration Date)

***Note:** The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.

Parent/Guardian Signature: _____ Date: _____

Part 2 – To be completed by licensed provider. Please print.

A. Describe the patient's disability/behavior and the major life activity affected by the disability:

B. Does the disability restrict the individual's diet? Yes No

If yes, the provider must complete C through F, sign and stamp the form with the office name and address.

C. List foods to be **omitted** from the diet and foods to be **substituted** (attach specific diet plan):

*Note: A specific diet plan **must** be provided before the school food service program can make any meal substitutions for the child.*

D. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up or chopped to bite-size pieces:

Finely ground:

Pureed:

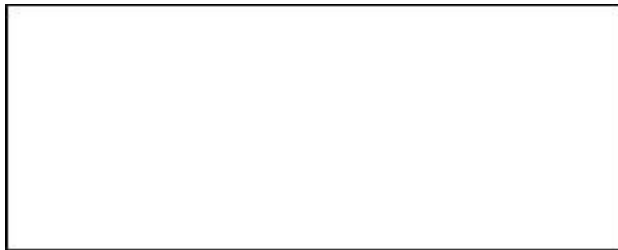
E. List any special equipment or utensils needed:

F. Indicate any other comments about the child's eating or feeding patterns:

Provider's Name: _____ Office Phone : (_____) _____

Provider's Signature: _____ Date: _____

Office Stamp:



In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
Program.Intake@usda.gov

This institution is an equal opportunity provider.