



Pace School

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Educational & Clinical Programs
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Human Resources
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July 9, 2026

Dear Parent/Guardian,

Pace School has a self-funded student breakfast and lunch program.

Your child's breakfast and lunch will be provided to them at no cost to you.

We have a partnership with The Nutrition Group, and we look forward to serving your child a nutritious breakfast and lunch throughout the school year.

For students who have a disability that restricts their diet, attached you will find a Medical Plan of Care for Food Service that your state licensed healthcare professional can complete. Upon completion of the form, please return it to the Pace School Health Office.

If you have any questions, please contact Steve Reubi, CFO, at 412-342-4361.

Thank you,

Steven Reubi, CPA, CFO

tlp

Medical Plan of Care for School Food Service

Student's Name	Date of Birth	Grade Level/Classroom
Name of School/Site		
Name of Parent/Guardian		Phone Number of Parent/Guardian
Signature of Parent/Guardian		Date
1. Provide an explanation below of how the student's physical or mental impairment restricts the student's diet:		
2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:		
3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. <u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable: ☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other:		
5. List any 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 the school to speak with the physician/medical authority.

Health Insurance Portability and Accountability Act Waiver
 In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, 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: _____