Special Dietary Needs Medical Statement

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 physician note or statement may be required. If you have any questions, please contact Jill Riggs Director of Food Service at 574-258-9552 or jriggs@phm.k12.in.us .

Parent/Guardian:

Student's 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 physical or mental impairment restricts the student's diet.			
Allergies and Intolerances	**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**	

Medical Authority:

Texture Modifications	**The child requires foods be:** ☐ Pureed ☐ Diced/Finely Ground ☐ Chopped/cut into bite-size pieces ☐ Other (please specify):	**Liquids should be:** ☐ Pudding Thick ☐ Honey/Nectar Thick ☐ Thinned ☐ Other (please specify):
Adaptive Eating	**Provide an explanation of how the student's physical or mental impairment restricts the student's diet**	
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 _____(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**:_____

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