Statement for Special Diet Prescription - VDH

The following child is a participant in one of the United Stated Department of Agriculture (USDA) programs: National School Lunch Program School Breakfast Program, After-school Snack Program, Summer Food Service Program or the Child and Adult Care Food Program. USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

Part 1: To be completed by Parent/Guardian

Child's Name	Date of Birth M F
Name of School/Center/Program:	Grade Level/Classroom:
Parent's/Guardian's Name	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 [Insert name of physician/medical authority] to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to [Insert School/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 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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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 [insert 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:_____
( ) Home Phone / ( ) Work Phone	
Address	
City, ST ZIP Code	Date:_____

Part 2: To be completed by Physician/Medical Authority

Does the child have a disability? Yes_____ No_____ If Yes, please describe the major life activities affected by the disability.	Does the child have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.
If the child is not disabled, does the child have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.	Does the child require emergency medication be administered? Yes_____ No_____ If yes, please list medication(s) and describe situation/reactions that would necessitate administrating.

Part 3: To be completed by Physician/Medical Authority

List any dietary restrictions or special diet:

List any food allergies or food intolerances:		
List foods to be substituted (mandatory):		
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All". Cut up/chopped into bite sized pieces: Finely Ground: Pureed:		
List any special equipment or utensils needed:		
Indicate any other comments about the child's eating or feeding patterns:		
Physician's Name and Office Phone Number:		Office Stamp
Physician's/Medical Authority Signature		Date
Part 4: Parent Signature		
Parent's/Guardian's Signature		Date
Part 5: Program Signature		
School/Program Official Signature		Date

*Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.