Medical Statement for Meal Modification

USDA regulations 7 CFR Part 15b require substitutions or modifications in school nutrition program meals for children whose disability restricts their diet and is supported by a statement signed by a recognized medical authority. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."

This form is intended to provide to the Coffee County School District some of the medical information necessary to determine a child's medically necessary nutritional needs/accommodations. A completed form must be signed by a licensed physician, advanced practice nurse (APN) with prescriptive authority (RXN), or a physician assistant (PA). It is strongly recommended that the prescribed diet order is updated annually with a new form.

Part 1: To be completed by Parent/Legal Guardian (Parent/Guardian should fill out Parts 1, 5 & 7 only)

Child's Name:		Date of Birth:	Student ID#:
School:		Grade Level/Classroom:	
Parent's/Legal Guardian's Name		Address, City, State, Zip Code	
Phone:	Alternate Phone:		

Part 2: Prescribed Diet Order for Children with a Documented Medical Need - To be completed by a licensed medical authority as specified above. All sections must be completed.

Specify the medical disability and how it restricts the child's diet:

What major life activity is affected by the student's medical disability? Example: Allergy to peanuts affects ability to breathe.

Type of Special Diet (diabetic, gluten-free, low sodium, etc.):

❑ Check if not applicable

Modified Texture: ∟not applicable ∟chopped ∟Ground ∟pureed

Modified Thickness of Liquids: ∟not applicable ∟nectar ∟honey ∟spoon or pudding thickness

Special Feeding Equipment (e.g. large handled spoon, sippy cup, etc.):

∟not applicable

Omit Foods Listed Below:

Substitute Foods Listed Below:

Physician/Medical Authority Printed Name :		Office Phone Number:
Physician/Medical Authority's Signature		Date
Part 5: Parent Signature		Date
Part 6: School Nutrition Program Director Signature		Date

Part 7: 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 official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____

(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: ttp://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.