

Statement for Special Diet Prescription - MARO ROAP

The following child is a participant in one of the United States 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:

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| Part 1: To be completed by Parent/Guardian | | Date of Birth _____ M F | |
| Child's Name _____ | | Grade Level/Classroom: _____ | |
| Name of School/Center/Program: _____ | | <p>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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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].</p> <p>This information is to be released for the specific purpose of Special Diet information.</p> <p>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.</p> <p>Parent/Guardian Signature: _____</p> <p>Date: _____</p> | |
| Parent's/Guardian's Name _____ | | | |
| () _____ Home Phone | () _____ Work Phone | | |
| Address _____ | | | |
| City, ST ZIP Code _____ | | | |

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| Part 2: To be completed by Physician/Medical Authority | |
| <p>Does the child have a disability? Yes _____ No _____</p> <p>If Yes, please describe the major life activities affected by the disability.</p> | <p>Does the child have special nutritional or feeding needs? Yes _____ No _____</p> <p>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.</p> |
| <p>If the child is not disabled, does the child have special nutritional or feeding needs? Yes _____ No _____</p> <p>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.</p> | <p>Does the child require emergency medication be administered? Yes _____ No _____</p> <p>If yes, please list medication(s) and describe situation/reactions that would necessitate administering.</p> |

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| Part 3: To be completed by Physician/Medical Authority |
| List any dietary restrictions or special diet: _____ |
| List any food allergies or food intolerances: _____ |

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| 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.