Dietary Modification Medical Statement Form

Rappahannock County Public Schools

School Year 2026-2027

Instructions: This form must be signed by a licensed healthcare professional, such as a licensed physician, physician assistant, or nurse practitioner. The school/division may contact the licensed healthcare professional for clarification of information provided on this form. Return this form to your child's school. This form must be submitted to ensure meal substitutions are made for children with disabilities. Mid-year changes require the submission of an updated and signed form.

Child's Name: _____

Child's Date of Birth: _____

Grade Level/Classroom: _____

Name of School/Site: _____

Student ID Number: _____

Name of Parent/Guardian: _____

Phone Number of Parent/Guardian: _____

_____

Signature of Parent/Guardian *Date*

Provide an explanation of how the student's physical or mental impairment restricts the student's diet:

_____

_____

_____

Document last modified on 08/01/2026

Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:

_____

_____

List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.

Foods to be omitted:

_____

_____

_____

Suggested substitutions:

_____

_____

_____

Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite sized pieces

☐ Ground/Finely Ground

☐ Pureed

☐ Other (please specify):

List any required special adaptive equipment:

_____

_____

_____

Signature of licensed healthcare professional[1] *Date*

Printed name and title of licensed healthcare professional:

Provider phone number:

Health Insurance Portability and Accountability Act Waiver

Signing the following section is optional but may prevent delays by allowing the school to speak with the physician/medical authority.

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 _____ (*name of licensed healthcare provider*) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to **Rappahannock County Public Schools Nutrition Department** 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 June 30, 2026. This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that they are the parent, guardian or representative of the student listed on this document and has the legal authority to sign on behalf of that person.

Signature of Parent/Guardian *Date*

School Nutrition Program Contact

For information or questions about requesting accommodations to school meals and the meal service for students with disabilities at Rappahannock County Public Schools, please contact:

Jackie Tederick
School Nutrition Director
Office: (540) 227-0023
Email Address:
jtederick@rappahannockschools.us

[1] A licensed healthcare professional in the state of Virginia is defined as a licensed physician, physician assistance, nurse practitioner, or registered dietitian.

USDA Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.