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 at

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