Special Dietary Needs Medical Statement Form

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 note from a medical authority may be required. If you have any questions, please contact Food Services Department at 845-620-3825 .

Parent/Guardian:

Student's Name	Date of Birth	Grade Level/Classroom	Name of School/Site
Name of Parent/Guardian		Phone Number of Parent/Guardian	

Disability/Medical Need of Student:

☐ Allergy ☐ Texture Modification

☐ Intolerance ☐ Other

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	Food should be:	Liquids should be:
	☐ Pureed	☐ Pudding Thick
	☐ Diced/Finely Ground	☐ Honey/Nectar Thick
	☐ Chopped/cut into bite-size pieces	☐ Thinned
	☐ Other (please specify):	☐ Other (please specify):

Additional Information	
	Provide an explanation of how the student's physical or mental impairment restricts the student's diet
	Describe any additional details for clarification such as required special adaptive equipment, reactions to allergies, etc.:

Name of Medical Authority & Title (please PRINT)	Provider Phone Number
Signature of 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 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. 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 child listed on this document and has the legal authority to sign on behalf of that child.

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 School Nurse Signature