Clear Form

Department of Food and Nutrition
Medical Statement for Meal Modifications

Section I – To be completed by parent or guardian.

1. Name of child: _____ 2. Birth date: _____
(Last) (First) (MI)

3. Name of parent or guardian: _____

4. Phone number (with area code): _____ 5. E-mail address: _____

6. Address: _____ City: _____ State: _____ Zip: _____

7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
printed name of child's recognized medical authority.

to release such protected health information of my child as is necessary for the specific purpose of special diet information to _____ and I consent to allow the recognized medical authority to freely
print name of school district

exchange the information listed on this form and in my child's records with the school district 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 I may rescind permission to release this information at any time, except when the information has already been released.

8. Signature of parent or guardian: _____ 9. Date: _____

Section II - Completed by child's recognized medical authority.

This section must be completed by the child's physician, physician assistant, doctor of osteopathy, registered dietitian nutritionist (RDN) or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment**: Does the child have a physical or mental impairment that restricts the child's diet?

☐ No ☐ Yes: Describe in detail how the child's physical or mental impairment restricts the child's diet.

11. Diet plan: Explain the diet/meal modification for the child. Attach a specific diet/meal plan, if needed.

12. Food omissions and substitutions: List foods to be omitted/substituted from the child's diet/meal plan.

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Section II - Completed by child's recognized medical authority, continued

13. **Food texture:** List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.

☐ Cut up or chopped into bite-size pieces: _____

☐ Finely ground: _____

☐ Pureed: _____

14. **Special Feeding Equipment**: List any special equipment or specialty utensils needed.

15. **Additional information**: Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification.

16. Printed name of recognized medical authority: _____ 17. Phone number _____

18. Signature of recognized medical authority: _____ 19. Date: _____

20. Office Stamp:

As policies indicate, provide information/ copy to:

☐ Food Service Manager/Sat. Assistant. Date:
☐ School Nurse/Clinic Date:
☐ Filed with student health records Date:
☐ 504 Committee Date:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 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/ad-3027.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

INSTRUCTIONS

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMODATION

1. Child Name: Print the name of the student that is requesting a meal modification.

2. Date of Birth: Print the date of birth of the student in 'month/ day/ year' format.

3. Parent or Guardian Name: Print the name of the person requesting the student's medical statement.

4. Telephone Number: Print the primary telephone number of the parent or guardian.

5. E-mail Address: List an email address that is current and checked regularly.

6. Address: Provide a home address where the student resides most of the time.

7. Name of Child's Recognized Medical Authority: Name of healthcare provider signing this form. Name of School District: **Miami Dade County Public Schools**

8. Parent or Guardian Signature: Signature of the person requesting the student's medical statement.

9. Date: Print the date the parent or guardian signed the document.

10. Check One: Check (✓) a box to indicate whether the student has a disability or does not have a disability. If the Student has a disability, provide a description of the student's Major Life Activity affected by the disability. Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life- threatening reaction or diabetes and needs timed meals with insulin).

11. Diet Plan and/or Accommodation: Describe a specific diet (or accommodation (e.g., soft foods) that has been prescribed by a physician or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods).

12. Foods to be Omitted and Substitutions: List specific foods that must be omitted (e.g., exclude fluid milk). If specific foods do not need to be omitted, skip this question. Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified milk).

13. Food Texture: Check (✓) a box to indicate the type of texture accommodation of foods that is needed. If the student does not need any texture modification, skip this question.

14. Adaptive Equipment: Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large, handled spoon, suction plate).

15. Additional Information: List any other information related to meals or eating that might be helpful.

16. Printed Name of Medical Authority: Print the name of the medical authority.

17. Telephone Number: Print the telephone number with the area code, of the medical authority.

INSTRUCTIONS

18. Signature of Medical Authority: Signature of the medical authority requesting a special meal or accommodation.

19. Date: Print the date the medical authority signed the form.

20. Office Stamp of Medical Authority: Must be completed by medical authority staff member and should include name of medical practice, address and phone number.