Dietary Modification Medical Statement Form

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: _____

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:

_____

_____

_____

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

List any required special adaptive equipment:

_____

_____

_____

Signature of licensed healthcare professional[1]

Printed name and title of licensed healthcare professional:

_____

Date: _____

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 **_____** (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to **Bedford County Public Schools** (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

Parent/Guardian Signature: _____ Date: _____

This institution is an equal opportunity provider.

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