Medical Statement for Children *with* Disabilities Requiring Special Meals in the U.S. Department of Agriculture (USDA) Child Nutrition Programs

This statement must be completed in its entirety and submitted to the school before any meal substitutions can be made for children with disabilities. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's physician.

Part I To be completed by parent/guardian. *Please print*

Child's Name: ______________________ Birth Date: ____________ ☐Male ☐Female

Parent/Guardian's Name: ____

Work Phone: __________________________ Home Phone: _______________________

Address: ________________________________ City: ____________ State: ____ Zip: ____

In accordance with the provisions of the Health Insurance Portability Act (HIPPA) of the 1996 and the Family Educational Rights and Privacy Act (FERPA) I hereby authorize

____

(Name of Physician)

To release such protected health information of my child as is necessary for the specific purpose of special diet information to

____

(Name of School)

And I consent to allow the physician to freely 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 sight 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 anytime except when the information has already been released. My permission to release this information will expire on ____________________________ *(*Expiration date)*

***Note:** The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.

Parent/Guardian Signature: __________________________________ Date: _____________

Part II To be completed by licensed physician. *Please print*

The Connecticut State Department of Public Health defines a licensed physician as a doctor of medicine or osteopathy.

A. Describe the patient's disability and the major life activity affected by the disability:

B. Does the disability restrict the individual's diet? ☐Yes ☐No

If yes, the physician must complete C through F on the next page, sign and stamp the form with the office name and address.

C. List foods to be omitted from the diet and foods to be substituted (attach specific diet plan):
Note: A specific diet plan must be provided before the school food service program can make any meal substitutions for the child.

D. List foods that require a change in texture. If all foods need to be prepared I this manner, indicate "All."
Cut-up or chopped to bite-size pieces:
Finely ground:
Pureed:

E. List any special equipment or utensils needed:

F. Indicate any other comments about the child's eating or feeding patterns:

Physician's Name: ______________________________ Office Phone Number: __________

Physician's Signature: __________________________ Date: _________________________

Office Stamp:

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