# Statement for Special Diet Prescription - VDH

The following child is a participant in one of the United Stated Department of Agriculture (USDA) programs: National School Lunch Program School Breakfast Program, After-school Snack Program, Summer Food Service Program or the Child and Adult Care Food Program. USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

**Part 1: To be completed by Parent/Guardian**

| | |
|---|---|
| Child's Name | Date of Birth M F |
| Name of School/Center/Program: | Grade Level/Classroom: |
| Parent's/Guardian's Name | 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 _____[Insert name of physician/medical authority] to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to Infant Toddler Family Day Care provider _____ 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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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 [insert date] _____. |
| ( ) Home Phone / ( ) Work Phone | This information is to be released for the specific purpose of Special Diet information. |
| Address | 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:_____ |
| City, ST ZIP Code | Date:_____ |

**Part 2: To be completed by Physician/Medical Authority**

| | |
|---|---|
| Does the child have a disability?<br>Yes_____ No_____<br>If Yes, please describe the major life activities affected by the disability. | Does the child have special nutritional or feeding needs?<br>Yes_____ No_____<br>If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority. |
| If the child is not disabled, does the child have special nutritional or feeding needs?<br>Yes_____ No_____<br>If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority. | Does the child require emergency medication be administered?<br>Yes_____ No_____<br>If yes, please list medication(s) and describe situation/reactions that would necessitate administrating. |

**Part 3: To be completed by Physician/Medical Authority**

List any dietary restrictions or special diet:

| | | |
|---|---|---|
| List any food allergies or food intolerances: | | |
| List foods to be substituted (mandatory): | | |
| List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".<br><br>Cut up/chopped into bite sized pieces:<br><br>Finely Ground:<br><br>Pureed: | | |
| List any special equipment or utensils needed: | | |
| Indicate any other comments about the child's eating or feeding patterns: | | |
| Physician's Name and Office Phone Number: | | Office Stamp |
| Physician's/Medical Authority Signature | | Date |
| | | |
| **Part 4: Parent Signature** | | |
| Parent's/Guardian's Signature | | Date |
| | | |
| **Part 5: Program Signature** | | |
| School/Program Official Signature | | Date |

*Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.