MEDICAL STATEMENT FOR CHILDREN WITH DISABILITIES
Requiring Special Meals in the USDA Child Nutrition Program for Fairfield Community Schools

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

Part 1 – To be completed by parent/guardian – PLEASE PRINT

Child's Name _____ Birth date: _____
(month, day, year)

Parent/Guardian Name: _____

Work Phone: _____ Home Phone: _____

Address: _____
(city, state, zip)

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPS) 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.

Parent/Guardian Signature _____ Date: _____

Review Annually, No changes: Parent/Guardian initials_____ Date_____ Parent/Guardian initials_____ Date_____

Parent/Guardian initials_____ Date_____ Parent/Guardian initials_____ Date_____

Part 2-To be completed by a recognized Medical Authority (MD, DO, NP, PA with prescriptive authority) PLEASE PRINT

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

B. Does the disability restrict the individual's diet? Y or N
(If yes, physician must complete C through F on the next page with signature)

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

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

E. List any special equipment or utensils needed:

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

Name of Recognized Medical Authority: _____

Office Phone Number: _____

Signature of Recognized Medical Authority: _____

Date: _____

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(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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