

Medical Plan of Care for School Food Service

Please read pages 1 and 2 before completing this form.

Student's Name	Date of Birth	Grade Level/Classroom
Name of School/Site		
Name of Parent/Guardian	Phone Number of Parent/Guardian	
Signature of Parent/Guardian	Date	
1. Provide an explanation below of how the student's physical or mental impairment restricts the student's diet:		
2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:		
3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. <u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable: <input type="checkbox"/> Chopped/Cut into bite-sized pieces <input type="checkbox"/> Diced/Finely Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Other:		
5. List any required special adaptive equipment:		
Name of Physician/Medical Authority & Title (Please Print)		Provider Phone Number
Signature of Physician/Medical Authority		Date
<p><i>Signing the following section is optional but may prevent delays by allowing the school to speak with the physician/medical authority.</i></p> <p>Health Insurance Portability and Accountability Act Waiver 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 _____ (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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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.</p> <p>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.</p> <p>Parent/Guardian Signature: _____ Date: _____</p>		

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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**
- (2) E-mail: program.intake@usda.gov.**

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