The Child and Adult Care Food Program TPC PROVIDER #_____

Statement for Special Diet Prescription

The following child is a participant in one of the United States 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/Caregiver

Child's Name:

Date of Birth:

Gender *(circle):* M F

Name of School/Center/Program/Provider:

Grade Level/Classroom *(if applicable)*:

Name of Caregiver/Guardian

Home Phone:

Work Phone:

Street Address:

City, State, Zip Code:

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 The Name of Physicians] to release such protected health information as is necessary for the specific purpose of Special Diet information to _____ [Insert Program Name] and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the 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 me. I understand that permission to release this information may be rescinded at any time except when the information has already been released.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].

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 authorized representative of the child listed on this document and has the legal authority to sign on behalf of that child.

Parent/Guardian Signature:_____

Date:_____

Part 2: To be completed by Physician/Medical Authority

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

Does the child have a disability?

Yes_____ No_____

If Yes, please describe the major life activities affected by the disability.

Does the child have special nutritional or feeding needs?

Yes_____ No_____

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 he/she have special nutritional or feeding needs?

Yes_____ No_____

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?

Yes_____ No_____

If yes, please list medication(s) and describe situation/reactions that would necessitate administrating.

Part 3: To be completed by a Recognized Medical Authority

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

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".

Cut up/chopped into bite sized pieces:

Finely Ground:

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 or Guardian Signature

Parent or Guardian Signature		Date

Part 5: Program Official Signature

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.**