## 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.
Foods to be omitted:

Suggested substitutions:

4. Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ 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 |

*Signing the following section is optional but may prevent delays by allowing the school to speak with the physician/medical authority.*

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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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.

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: _____ Date: _____