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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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