EF-E
Rev 6/2021

Dietary Modification
Medical Statement Form
School Year 2023-24

Instructions: This form must be signed by a licensed healthcare professional, such as a licensed physician, physician assistant, or nurse practitioner. The school/division may contact the licensed healthcare professional for clarification of information provided on this form. Return this form to your child's school. This form must be submitted to ensure meal substitutions are made for children with disabilities. Mid-year changes require the submission of an updated and signed form.

Child's name: _____

Child's date of birth: _____

Grade: _____ School: _____

Name of Parent/Guardian: _____

Phone Number of Parent/Guardian: _____

_____ _____

Signature of Parent/Guardian Date

Provide an explanation of how the student's physical or mental impairment restricts the student's diet:

_____

_____

Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:

_____

_____

List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. Foods to be omitted:

_____

_____

Suggested substitutions:

_____

_____

Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite sized pieces ☐ Other

☐ Ground/Finely Ground ☐ Pureed

List any required special adaptive equipment:

_____

_____

_____ _____

Signature of licensed healthcare professional **Date**

Printed name & title of healthcare professional: _____

Phone number: _____

Health Insurance Portability and Accountability Act Waiver

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

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 the above medical authority to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to Giles County Public Schools 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 at the end of school year 2021-22. 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**

This institution is an equal opportunity provider.