

Please email signed form to: nurse@archimedean.org**Section I – To be completed by parent or guardian.**

1. Name of child: _____
Last First MI
2. Birth Date _____
3. Name of parent or guardian: _____
4. Phone number (with area code): _____
5. E-mail address: _____
6. Address: _____ City: _____ State: _____ Zip: _____
7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
printed name of child's recognized medical authority.
to release such protected health information of my child as is necessary for the specific purpose of special diet information to _____
print name of school district and I consent to allow the recognized medical authority to freely exchange the information listed on this form and in my child's records with the school district 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 I may rescind permission to release this information at any time, except when the information has already been released.
8. Signature of parent or guardian: _____
9. Date _____

Section II - Completed by child's recognized medical authority.

This section must be completed by the child's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment:** Does the child have a physical or mental impairment that restricts the child's diet?

No **Yes** Describe in detail how the child's physical or mental impairment restricts the child's diet.

11. **Diet plan:** Explain the diet/meal modification for the child. Attach a specific diet/meal plan, if needed.

12. **Food omissions and substitutions:** List foods to be omitted/substituted from the child's diet/meal plan.

Please email signed form to: nurse@archimedean.org**Section II - Completed by child's recognized medical authority, continued**

This section must be completed by the child's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

13. Food texture: List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.

Cut up or chopped into bite-size pieces: _____

Finely ground: _____

Pureed: _____

14. Special Feeding Equipment: List any special equipment or specialty utensils need

15. Additional information: Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification.

16. Printed name of recognized medical authority: _____ **17. Phone** _____

18. Signature of recognized medical authority: _____ **19. Date:** _____

20. Office Stamp:

As policies indicate, provide information/ copy to:

Food Service Manager/Sat. Assistant. **Date:** _____

Filed with student health records **Date:** _____

School Nurse/Clinic **Date:** _____

504 Committee **Date:** _____

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