## Dietary Modification

## Medical Statement Form

## SY2021-2022

***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:** Click or tap here to enter text.

**Child’s date of birth:** Click or tap here to enter text.

**Grade level/classroom:** Click or tap here to enter text.

**Name of School/Site:** Click or tap here to enter text.

**Name of Parent/Guardian:** Click or tap here to enter text.

**Phone Number of Parent/Guardian:** Click or tap here to enter text.

**Signature of Parent/Guardian**

**Date:** Click or tap here to enter text.

**Provide an explanation of how the student’s physical or mental impairment restricts the student’s diet:** Click or tap here to enter text.

**Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student’s needs:** Click or tap here to enter text.

**List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. Foods to be omitted:** Click or tap here to enter text.

**Suggested substitutions:** Click or tap here to enter text.

**Indicate texture modifications, if applicable:**

Chopped/Cut into bite sized pieces

Ground/Finely Ground

Pureed

Other

**List any required special adaptive equipment:** Click or tap here to enter text.

**Signature of licensed healthcare professional[[1]](#footnote-1)**

**Printed name and title of licensed healthcare professional:** Click or tap here to enter text.

**Date:** Click or tap here to enter text.

**Provider phone number:** Click or tap here to enter text.

**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 Click or tap here to enter text.(medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to **Lynchburg City 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 on Click or tap here to enter text. (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:** Click or tap here to enter text.

This institution is an equal opportunity provider.

1. A licensed healthcare professional in the state of Virginia is defined as a licensed physician, physician assistance, or nurse practitioner. [↑](#footnote-ref-1)