Hancock School ISD #768
Special Diet Statement
For a Participant *Without* a Disability

This Special Diet Statement is **only** for a participant without a disability who is medically certified as having a special dietary need.

This form should be updated whenever the participant's diagnosis or special diet changes.

Sponsors who operate Child Nutrition Programs are not required to accommodate a request for a dietary modification for a participant without a disability but are encouraged if the request if considered reasonable.

If the requested accommodation is for a participant with a disability or is life threatening complete and submit the Diet Statement for a Participant With a Disability.

Part 1: Participant Information
Parent or guardian must complete. Please print.

Participant's Name: Last/First/Middle Initial _____ Today's Date _____

Name of School/Center/Site Attended _____ Date of Birth _____

Parent/Guardian Name _____ Home Phone Number _____ Work Phone Number _____

Parent/Guardian Address _____ City _____ State _____ Zip Code _____

Meals or snacks to be eaten at school/center/site: (check all that apply)

School:	**Center/Child Care/Adult Care Center:**	**Site—Summer Food Service Program:**
☐ Breakfast	☐ Breakfast	Breakfast ☐
☐ Lunch	☐ Lunch	Lunch ☐
☐ Afterschool Care Program	☐ Supper	Supper ☐
	☐ Snack (am/pm/eve)	Snack ☐
	☐	

Parent/Guardian Signature:_____ Date:_____
OR Participant's Signature (Adult Day Care)

Part 2: Participant Status
Recognized medical authority must complete. Please print.

Participant does *not* have a disability but is requesting a special meal or dietary accommodation.

1. Describe and/or select the medical or special dietary condition which restricts the participant's diet:

_____

_____

_____

Part 3: Dietary Accommodation
Recognized medical authority must complete. Please print.

Foods to be omitted and substitutions: List specific foods to be omitted **and** foods to be substituted. You May attach a sheet with additional information.

Foods to be Omitted	Foods to be Substituted

☐ **Texture Modification**: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other:_____

☐ **Other Dietary Modification OR Additional Instructions** (describe). Attach specific diet order instructions:

_____

Signature

A recognized medical authority (licensed physician, physician assistant, certified nurse practitioner, registered dietitian, licensed nutritionist or chiropractor) must sign and retain a copy of this document.

Recognized Medical Authority Name/Credentials (print):_____ Date:_____

Signature:_____ Clinic/Hospital Name:_____

Phone Number:_____ Fax Number:_____

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may authorize the director of the school/center/site to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ (physician/medical authority name) to release such protected health information as is necessary for the specific purpose of Special Diet information to _____ (program name) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the 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 me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. Optional: 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 authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian/: _____ Date: _____
OR Participant's Signature (Adult Day Care)

This institution is an equal opportunity provider.