

Dietary Modification
Medical Statement Form
Chesapeake Public Schools



2021-2022

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. This form must be submitted to ensure meal substitutions are made for children with disabilities, including food allergies. Mid-year changes require the submission of an updated and signed form.

Return this form to School Nutrition Services, ATTN: Jennifer McDermott, Nutrition & Wellness Educator at Jennifer.mcdermott@cpschools.com or by fax at 757.547.0916.

Child's name:

Child's date of birth:

Grade level/classroom:

Name of School/Site:

Name of Parent/Guardian:

Phone Number of Parent/Guardian:

Signature of Parent/Guardian

Date:

Describe the student's medical condition or disability that requires dietary modifications:

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:

(FORM CONTINUED ON NEXT PAGE)

Indicate texture modifications, if applicable:

- Chopped/Cut into bite sized pieces
- Ground/Finely Ground
- Pureed
- Other

List any required special adaptive equipment:

Signature of licensed healthcare professional¹

Printed name and title of licensed healthcare professional:

Date:

Provider 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 _____ (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:

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.