

## Special Diet Statement to Request Dietary Accommodations

**Participant Information:**  
**Parent or guardian must complete. Please print clearly.**

Name of Child Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Parent or Guardian Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Child Care Provider Name: \_\_\_\_\_ PCI Child Care Provider #: \_\_\_\_\_

Child Care Provider Phone #: \_\_\_\_\_

**Participant Medical Information**

**Licensed medical professional must complete (MD, DO, NP, PA). Please print clearly.**  
**State the medical condition, disability, physical or mental impairment or food allergies requiring a special meal or dietary accommodation.** Provide a brief description of participant's major life activity (such as eating) or bodily function that is affected by the medical condition.

**Dietary Accommodation**

**Licensed medical professional must complete (MD, DO, NP, PA). Please print clearly.**  
**Foods to be omitted and recommended substitutions:** list specific foods to be omitted and specific foods to be substituted. (You may attach a sheet with additional information as needed).

Foods to be Omitted	Foods to be Substituted

Exempt Infant Formula:  Nutramigen  NeoSure  Alimentum  Other: \_\_\_\_\_

Texture Modifications:  Bite Size Pieces  Ground  Pureed  Other: \_\_\_\_\_

Tube Feeding: Formula Name: \_\_\_\_\_

Administering Instructions: \_\_\_\_\_

Oral Feeding:  No  Yes If yes, specify foods: \_\_\_\_\_

**Signature**

**Licensed physician, physician assistant, or nurse practitioner must sign and retain a copy of this document.**

Signature of Medical Authority: \_\_\_\_\_ Credentials: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Clinic Name \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

This institution is an equal opportunity provider.

## Voluntary Authorization

Note to Parent(s)/Guardian(s): You may authorize Providers Choice, Inc. 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 Providers Choice, Inc. and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning \_\_\_\_\_ **(participant's name)**, 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.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632 9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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