Logansport Community School Corporation

DIET PRESCRIPTION/ALLERGY FORM

School Year: _____

***Indicates required field/must be completed.**

*Student's Name:_____DOB:_____

*School:_____GRADE:_____

*Parent/Guardian Name: _____

Signing the following section is optional, but may prevent delays by allowing school personnel to speak with the medical authority.

Health Insurance Portability and Accountability Act Waiver (HIPPA)

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act (FERPA), 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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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:_____

*Diet Prescription (check one or more):

☐ **Disability, Medical Need, Impairment (specify):**

_____

☐ **Diabetic** ☐**Calorie-Controlled** ☐**Other (describe):**_____

Texture Modification: ☐**Chopped** ☐ **Ground** ☐**Pureed**

[ ] Non-disabling allergy/food sensitivity

[ ] Disabling Allergy (includes severe and/or anaphylaxis)

*Major life activity affected by the student's **disability** (check one or more)

☐ Caring for Self
☐ Performing Manual Tasks
☐ Walking
☐ Seeing
☐ Hearing
☐ Speaking
☐ Breathing
☐ Eating/Digestion
☐ Learning
☐ Performing Manual Tasks
☐ Other:_____

*Omitted Foods/Beverages	*Allowed Substitution(s)

AdditionalOrders/Recommendations_____

_____

***I certify that the above named student needs special meals prepared as described above due to a disability/medical condition/impairment.**

*Medical Authority Signature	Medical Authority Printed Name	Office Phone Number	Date

*A qualified medical authority is a medical professional who has prescriptive privileges in the state of Indiana.

PLEASE RETURN COMPLETED FORM TO your school NURSE
Questions? Contact Food Service Department at (574) 722-2911
Orders will stay in effect until we receive notification in writing of a change in status.

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.

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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, 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.

This institution is an equal opportunity provider.