Child Care & Nutrition, Inc.
We care about you, because you care about kids!

Address: PO Box 138 • Ivanhoe • MN • 56142
Phone: 800.634.3359
Email: info@childcarenutrition.com
Website: www.childcarenutrition.com
Facebook: facebook.com/childcarenutrition/

Special Diet Statement To Request Dietary Accommodations

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

Parent or guardian must complete. Please print.

Name of Child Participant: _____ Date of Birth: _____

Name of Parent or Guardian: _____

Parent/Guardian Phone #: _____ Parent/Guardian Email: _____

Child Care Provider's Name: _____ Provider ID: _____

Parent/Guardian Signature: _____ Date: _____

Participant Medical Information: Licensed medical professional must complete (MD, DO, NP, PA) Please print.

State the medical condition, disability, physical or mental impairment, or food allergies that require a special meal or dietary accommodation. Please also provide a brief description of the participant's major life activity or bodily function that is affected by the medical condition (such as eating, bowel movements, etc.)

_____

_____

_____

Dietary Accommodation: Licensed medical professional must complete (MD, DO, NP, PA) 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. Must be completed for form to be valid.

Foods to be Omitted	Foods to be Substituted

Exempt infant formulas: ☐ Nutramigen ☐ Alimentum ☐ NeoSure ☐ EleCare ☐ Other: _____

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

Tube Feeding: Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

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

_____

Signature

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document.

Prescribing Authority Credentials (print): _____ Date: _____

Signature: _____ Clinic/Hospital: _____

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 **Child Care & Nutrition, Inc., (CCNI)** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning _____ (participant 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 _____ (participant name). 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)

Nondiscrimination statement: 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, you have two options: 1. Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at Filing a Program Discrimination Complaint as a USDA Customer, and at any USDA office; or 2. Write a letter addressed to USDA; 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 one of the following methods:

(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.