Spokane Head Start/ECEAP/Early Head Start

REQUEST FOR SPECIAL DIETARY ACCOMMODATIONS

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| **PARENT AUTHORIZATION FOR RELEASE OF INFORMATION** | | | | | | | | | | | | | | | | | | | | | |
| I hereby authorize Head Start/ECEAP/EHS and my child’s medical provider, | | | | | | | | | | | | | | | | | | | | | |
| (Provider name) | | | |  | | | | | | | | | | | | | | | | | |
| **To receive and disclose information regarding dietary treatment recommendations for:** | | | | | | | | | | | | | | | | | | | | | |
| Child’s name | | |  | | | | | | | | | | | | Birth date | | | | |  | |
| Parent/legal guardian (please print) | | | | | | |  | | | | | | | | | | | | | | |
| Parent’s/guardian’s signature | | | | | |  | | | | | | | | | | Date | | | |  | |
| Mailing Address | | | |  | | | | | | | | City/State/Zip | | | | | | | |  | |
| Phone |  | | | | Site | | |  | | | | | | | | | | | | | |
| FSC |  | | | | | Room Number | | |  | | | | | AM  PM  Full Day  Duration | | | | | | | |
| AUTHORIZATION IS VALIED FOR PROGRAM YEAR, BEGINNING | | | | | | | | | | |  | | | | | | AND ENDING | | | |  |
| PARENT/GUARDIAN MAY REVOKE THIS AUTHORIZATION AT ANYTIME IN WRITING. | | | | | | | | | | | | | | | | | | | | | |
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| **MEDICAL PROVIDER: PLEASE COMPLETE SECTION BELOW** | | | | | | | | | | | | | | | | | | | | | |
| **Diet Order** | | | | | | | | | | | | | | | | | | | | | |
| Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment, which substantially limits a major life activity, or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences. | | | | | | | | | | | | | | | | | | | | | |
| **1. Describe how the impairment affects the child** (i.e., how the ingestion/contact with the food impacts the child) | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **2. Explain what must be done to accommodate the child’s diet** (i.e. specific food(s) to be omitted/avoided from the child’s diet): | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **3. List food(s) and/or beverages to be substituted, provided, or modified:** | | | | | | | | | | | | | | | | | | | | | |
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| Signature of State-Recognized Medical Authority\* | | | | | | | | | | | | |  | | | | | Date | | | |
| Clinic Name | |  | | | | | | | | Phone | | | | | | | | |  | | |
| \*State-Recognized Medical Authority is a licensed health care professional authorized to write medical prescriptions in Washington: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician’s Assistant (PA) with prescriptive authority, Naturopathic Physician, or Advanced Registered Nurse Practitioner (ARNP). | | | | | | | | | | | | | | | | | | | | | |
| **PLEASE RETURN THIS FORM TO** | | | | | | | | | | **RETURN THIS FORM TO:** | | | | | | | | | | | |