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:** |
|       |
|       |  |       |
| 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:** |