PROVIDERS CHOICE

P.O. Box 390813, Minneapolis, MN 55439
952-944-7010 • 800-356-5983 • fax: 952-944-7011

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 or Center Name: _____ PCI 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.

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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 _____ **(child 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. I understand that permission to release this information may be rescinded at any time except when the information has already been released.

Parent Signature _____ Date _____

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.