MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Child and Adult Care Food Program

1. Institution Name	2. Institution Address
3. Name of Participant	4. Age or Date of Birth
5. Name of Parent or Guardian	6. Telephone Number

7. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions on reverse side of this form.) Institutions participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A State recognized medical authority must sign this form. A State recognized medical authority is a State licensed health care professional who is authorized to write medical prescriptions under State law.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Institutions participating in federal nutrition programs are encouraged to accommodate reasonable requests.

☐ Participant does not have a disability, but is requesting a special accommodation for meals. Institutions participating in federal nutrition programs are encouraged to accommodate reasonable requests.

8. Disability or medical condition requiring special meals or accommodations:

9. Special meals and/or accommodation: *(Describe in detail to ensure proper implementation. Use attachments as needed)*

10. Signature of Parent or Guardian*	11. Printed Name	12. Telephone Number	13. Date
14. Signature of Medical Authority*	15. Printed Name	16. Telephone Number	17. Date

*A parent or guardian and physician's signature is required for participants with a disability. A parent/legal guardian signature alone is acceptable for special medical or dietary needs that are not a disability.

INSTRUCTIONS

REQUEST FOR SPECIAL MEALS AND/OR ACCOMMODATIONS

1. Institution Name: Print the name of the institution that is providing the form to the parent.
2. Institution Address: Print the address of site where meal will be served.
3. Name of Participant: Print the name of the child or adult participant to whom the information pertains.
4. Age of Participant: Print the age of the participant. For infants, please use date of birth.
5. Name of Parent or Guardian: Print the name of the person requesting the participant's medical statement.
6. Telephone Number: Print the telephone number of parent or guardian.
7. Check One: Check (X) a box to indicate whether the participant has a disability or does not have a disability.
8. Disability or medical condition requiring a special meal or accommodation: Describe the disability or medical condition that requires a special meal or accommodation (e.g., allergy to peanut, etc.)
9. Special meals and/or accommodations: Describe the purpose, requirements, foods allowed or disallowed, appropriate substitutions, amounts, the schedule, and other details and instructions.
10. Signature of Parent or Guardian: Signature of the parent or guardian completing form.
11. Printed Name: Print name of the person completing form.
12. Telephone Number: Telephone number of person completing form.
13. Date: Date preparer signed form.
14. Signature of Medical Authority: Signature of medical authority requesting the special meal or accommodation.
15. Printed Name: Print name of medical authority.
16. Telephone Number: Telephone number of medical authority.
17. Date: Date medical authority signed form.

The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual.

(For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008.)

Information regarding the ADAAA, which expanded the definition of disability, can be found at:
http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf

Notice of Use of Protected Health Information

Effective Date: 4/14/2003

Institution Name:

HIPAA / PHI:

Your child's privacy and the protection of his/her health information are important to this facility. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we are required to maintain the privacy of your child's Protected Health Information (PHI) and to provide you with this notice regarding our practices with respect to your child's PHI. This notice describes how your child's medical information may be used and disclosed, and how you can get access to this information. Please read this notice carefully.

This facility may receive PHI from your child's medical providers as part of the requirements of the program or to better meet your child's individual needs while s/he is enrolled at this facility.

This facility maintains an efficient and effective record-keeping system with policies and procedures that provide information about who has access to children's files and the information in them. All staff members who may have access to children's files will abide by our confidentiality policy.

If you think that some of the information on file as PHI is wrong, you may request in writing that it be changed or new information be added.

This facility will share information with staff only on a "need-to-know" basis to perform child care duties. The sharing of any PHI is to ensure that your child's health needs are met and their safety is maintained at all times. Any information shared with others is shared only after a Release of Information form is signed by the child's parent or guardian.

This facility will share information which may include PHI with individuals, agencies, and/or teams who oversee this facility for compliance, licensure, and inspections. Examples of these are: the Montana Child and Adult Care Food Program, County or State Health Department(s), Indian Health Services, Tribal Health Departments, and the Montana Quality Assurance Bureau.

This facility allows you to inspect your child's file containing PHI at any time with the assistance of a staff member. This facility maintains a log of all incidences of sharing PHI. You can request and receive a list of where your child's PHI has been shared.

If you have concerns about this notice, please ask the individual providing it. If that person cannot answer your questions, please call the Montana Department of Public Health and Human Services (DPHHS) PHI Officer at 1-800-645-8408.

To file a complaint regarding health privacy violations, write to the 'Secretary of Health and Human Services, US Department of Health and Human Services, 200 Independence Avenue SW, Room 506-F, Washington, DC 20201'. This must be done within 180 days from the date you believe your child's health privacy was violated. You may also call the Office of Civil Rights at 1-866-627-7748. This facility will not retaliate in any way if you file a complaint.

I have been given a copy of this Notice and have been given the opportunity to ask questions concerning how my child's PHI will be used. I know that I can contact this facility's director or the DPHHS PHI Officer at (800) 645-8408 if I have further concerns.

Name of Participant:	
Parent/Guardian Signature:	Date: