



**ATHLOS
LEADERSHIP
ACADEMY**

School Food Authorities (SFAs) are required to make substitutions to meals for children with a disability that restricts the child's diet on a case-by-case basis and only when supported by a written statement from a state licensed healthcare professional, such as a physician, who is authorized to write medical prescriptions under state law.

SFAs are not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference.

In order to review your student's needs and provide appropriate accommodations, a medical statement must be completed and submitted by a licensed physician, physician's assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. The medical statement must be completed on letterhead from the medical office and must include the name, medical title, mailing address, phone number and fax number of the medical professional who issued the medical statement.

The following required dietary information must be included on the medical statement in order for it to be processed. Please ensure that the medical professional answers each of the following questions, in detail, before submitting.

- 1. Please list all food allergens or foods to be avoided. Beside each allergen, please provide a brief explanation of how this food affects the child.***
- 2. Please list any advised alternatives, if applicable. Attach a page with additional instructions as needed.***
- 3. Please note any additional dietary disabilities and accommodations required. (Example- Tube Feeding, Oral Feeding, Texture Modification.)***

The medical statement may be returned to the school in person or in one of the following ways:

Mail

Athlos Leadership Academy
Food and Nutrition Program
10100 Noble Parkway North
Brooklyn Park, MN 55421

Fax

Athlos Leadership Academy
Food and Nutrition Program
Fax- 763-315-0601

The licensed medical professional must sign and retain a copy of the issued medical statement.

It is likely that our Food Service Director may have questions regarding the medical statement and may need to reach out to the medical professional for clarifications. By completing the voluntary authorization below, you are granting permission for the school's Food Service Director or School Nurse to communicate directly with the medical professional who submitted the medical statement for your child.

Parent- Voluntary Authorization

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:

Name of Medical Professional: _____

Medical Office: _____

Address: _____

Phone Number: _____

Fax: _____

to release such protected health information as is necessary for the specific purpose of Special Diet information to **Athlos Leadership Academy** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, 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 my child. 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: _____

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, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) [found online](#) at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and 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:

- (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.

This Box is for Athlos Leadership Academy Office Use Only

Master copy of this form is to be attached to the master copy of the medical statement provided by the physician. Forms are then to be retained by the Food Service Director for meal accommodation planning. Storage of forms must follow regulations for private student data.

Secondary copy of this form and medical statement must be stored in student’s health file in the school’s Health Office. Storage of forms must follow regulations for private student data.

Date completed form received by Food Service Director: _____

Date copy given to the Health Office: _____

Results of review: (Check one)

Medical Statement contains all necessary information. No follow up required. _____

Medical Statement is lacking necessary details. Follow up required: _____

Follow Up Correspondence:
Date of follow up correspondence between Food Service Director or School Nurse and physician (If applicable) _____

****If clarifications are required, updated copies must be filed in the Food Service Director files and Health Office files.**