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| **Parent, please attach current photo**  **of Student**  **HERE** |

**DEPARTMENT OF STUDENT SUPPORT SERVICES OFFICE OF HEALTH SERVICES**

# OHS-18 : Medical Statement for Student Requiring Special Meals

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian of student listed above, give my **PRINT FIRST AND LAST NAME**

permission for school staff to contact my child’s primary care physician to obtain or release information concerning a required special diet. This information will only be shared with St. Louis Public School’s personnel and the service providers who need to information to provide and prepare the special diet. This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice to withdraw my consent. I recognize this information, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

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**PARENT/GUARDIAN SIGNATURE**

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**THIS SECTION IS TO BE COMPLETED BY PRESCRIBING PHYSICIAN:**

**Please authorize the appropriate diet and other instructions:**

* Blended diet (pureed)
* Mechanically altered diet
* Thickened liquids (Thick-It)
* Soft Diet
* Diet appropriate for developmental level
* Other (specify)

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* Food restrictions/allergies (specify)

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**Printed Name of Prescribing Physician Signature of Prescribing Physician Date**

**Prescribing Physician’s Phone Number Office Address**

**OHS-18 06/2019**

