

MEDICAL STATEMENT
For
CHILDREN WITH DIETARY RESTRICTIONS
Requiring Special Foods in Child Nutrition Programs

Part I (to be filled out by School District or Parent/Guardian)

Name of Student: _____ Age: _____

Name of Parent/Guardian: _____ Phone: _____

School district: _____ School Attended by Student: _____

Part II (must be filled out by Physician)

Diagnosis (Include description of the patient's disability and the major life activity affected by the disability): _____

List food(s) to be omitted from diet: _____

List food(s) that may be substituted for omitted food(s): _____

List any modifications of texture or consistency that are necessary: _____

Date

Signature of Physician

Physician's Printed Name

Physician's Phone Number