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): ____

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

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

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

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_________________________   _____________________________________
Date   Signature of Physician

____
Physician's Printed Name

____
Physician's Phone Number