MEDICAL STATEMENT
FOR
CHILDREN *WITH* DISABILITIES
Requesting Special Foods in Child Nutrition Programs

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

Name of Student: _____ Age: _____

Name of Parent/Guardian: _____ Telephone Number: _____

School District: _____ School Attended by Student: _____

Part II (to be filled out by a 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 (diet plan) and any modifications of texture or consistency that are necessary:

_____

_____

_____

_____

_____ _____

Date Signature of Physician

Physician's Telephone Number: _____