Medical Statement for
Non-Disabled Students with Medical or Other Special Dietary Needs
Requiring Special Foods in Child Nutrition Programs

Part I To be competed by School District or Parent/Guardian

Date: ____

Name of Student: ____

School District: ____

School Name: ____

Part II To be completed by one of the following medical authorities: Licensed Physicians (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practitioners (NP), Registered Nurses (RN), Naturopathic Physician (ND), Doctor of Osteopathy (DO), and Naturopathic Doctor of Osteopathy (NDO)

Patient's Name ____ Age __________

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the patient's diet)

____

____

____

____

List foods to be omitted from diet:

____

____

____

____

List foods to be substituted:

____

____

____

____

____

Date ______________ Signature of Medical Authority________________________

This Institution is an equal opportunity provider.