

**Medical Statement for
Students with Disabilities
Requiring Special Foods in Child Nutrition Programs**

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

Date: _____
Name of Student: _____
School District: _____
School Name: _____

Part II To be completed by Licensed Physician

Patient's Name: _____ Age: _____
Diagnosis (include description of the patient's disability and the major life activity affected by the disability): _____ _____ _____
Does the disability restrict the patient's diet? Yes _____ No _____ If yes, list how disability restricts diet: _____ _____ _____

Diet Plan: Foods to be omitted from diet: _____ _____ _____ _____ Foods to be substituted (include modifications of texture or consistency that may be necessary): _____ _____ _____ _____

Date: _____ Signature of Physician: _____

This Institution is an equal opportunity provider.