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

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

Name of Student: ____ Age: _____________________

Name of Parent/Guardian ____________________________________ Telephone Number: __________________

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):

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List food(s) to be omitted from diet:

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List food(s) that may be substituted (diet plan) and any modifications of texture or consistency that are necessary:

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Date

____
Signature of Physician

Physician's Telephone Number: _______________________