Medical Statement for Students with Special Dietary Needs In Child Nutrition Programs

Student's Name: _____ **Age:**_____

School Name: _____ **Grade Level:**_____ **Classroom:** _____

Please check one box below:

Does the student have a disability that requires the student to have a special diet or feeding equipment/utensils?

☐ **Yes**

If Yes, describe the disability and the major life activity affected by the disability. The form must be signed by a physician. Return it to the school when completed.

Describe the disability/diagnosis: _____

_____

If the student is NOT disabled, does he/she have a medically certified special dietary need?

☐ **Yes**

If Yes, the form must be signed by a physician, physician assistant or nurse practitioner. Return it to the school when completed.

Diet Prescription: (used back of form if more space is needed)

List Food Allergies/Intolerances (list specific food(s) to be omitted):_____

_____

List Allowable Food Substitutions: _____

_____

Indicate any texture modifications and which foods need to be modified:

☐ Chopped/Cut up: _____

☐ Ground: _____

☐ Pureed: _____

☐ Liquid Modifications: Honey / Nectar / Other (specify)

List special equipment/utensils needed:

_____

_____

Additional comments about the student's eating patterns or dietary modifications:

Physician's or Medical Authority's Signature: _____ Date: _____