MEDICAL STATEMENT
For Children with Disabilities Requiring Special Needs In Child Nutrition Programs

PART I

Date ______________________________

Child's Name ____ Age __________________

School District __________________________ School ________________________________

PART II (To Be Completed By Physician)

Diagnosis: ____

Describe the child's disability and the major life activity affected by the disability: _______________

____

Does the disability restrict the child's diet? Yes _____ No _____

List dietary restrictions or special diet: ____

____

List allergies or food intolerances: ____

____

List foods that require a change in texture: ____

____

List required special equipment: ____

____

Date _______________ **Signature of Physician** _______________________________________

PART III (Parent/Guardian Signature)

Date _______________ **Signature of Parent/Guardian** __________________________________

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