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

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

Name of Student: _____ Age: _____

Name of Parent/Guardian: _____ Telephone Number: _____

School District: _____ School Attended by Student: _____

**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):

_____

_____

_____

List food(s) to be omitted from diet:

_____

_____

_____

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

_____

_____

_____

_____

_____ _____

Date Signature of Physician

Physician'sTelephone Number: _____

# MEDICAL STATEMENT
# FOR
# CHILDREN *WITHOUT* DISABILITIES
## Requesting Special Foods in Child Nutrition Programs

**Part I** (to be filled out by SFA or Parent/Guardian)

Name of Student: _____ Age: _____

Name of Parent/Guardian: _____ Telephone Number: _____

School District: _____ School Attended by Student: _____

**Part II** (to be filled out by a recognized Medical Authority)

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

_____

_____

_____

List food(s) to be omitted from diet:

_____

_____

_____

List food(s) that may be substituted (diet plan):

_____

_____

_____

Additional information:

_____

_____

_____

_____ _____

Date Signature of Recognized Medical Authority

Telephone Number: _____