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: ______________________________

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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: (use back of form if more space is needed)

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

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List Allowable Food Substitutions: ______________________________

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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:

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

Physician's or Medical Authority's Signature: ______________________ Date: __________