

**Exhibit 6.1. Medical Statement for Disabled Child**

**Mississippi Department of Education  
Office of Child Nutrition  
Medical Statement for Disabled Child**

**Part I** (to be completed by School District/School/Organization/Sponsor)

Date \_\_\_\_\_

Name of School District/School/Organization/Sponsor \_\_\_\_\_

Name of Student/Disabled Person \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

School/Provider/Center Name \_\_\_\_\_

School/Provider/Center Address \_\_\_\_\_

**Part II** (to be completed by the Physician)

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

Diagnosis \_\_\_\_\_

Describe the individual's disability and the major life activity affected by the disability \_\_\_\_\_

Does the disability restrict the individual's diet? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list food(s) to be omitted from diet and food(s) that may be substituted \_\_\_\_\_

Special equipment needed \_\_\_\_\_

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Physician