West Point Consolidated School District
Office of Child Nutrition
Medical Statement for Non-Disabled Child

Please return this form to:

West Point Consolidated School District
Office of Child Nutrition
Phone: 662-494-6370
Fax: 662-494-8605

Part 1 (to be completed by School District or guardian)

Date: _____

Name of School District: **West Point Consolidated School District**

Address: **P.O. Box 656, 359 Commerce Street, West Point, MS 39773**

Name of Student:_____

Student's Address: _____

_____ Student's Date of Birth: _____

School Attended by Student: _____

Part II (to be completed by the Medical Authority)

Patient's Name: _____ Age: _____

Diagnosis: _____

_____

Describe the medical or other special dietary needs that restrict the child's diet:_____

_____

_____

List food(s)* to be omitted from the diet and food(s) that may be substituted: _____

_____

_____

Special equipment needed: _____

_____

_____ _____

Date Signature of Medical Authority

*For patients with milk restrictions please give clarification. Does the patient have a milk intolerance or a milk allergy? Can the patient have milk as an ingredient such as in cornbread, or in a casserole, or as cheese on a pizza but just not tolerate milk to drink?_____

_____