MEDICAL STATEMENT

Requesting Special Foods in Child Nutrition Programs

Part I (to be filled out by 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 state licensed healthcare professional or a registered dietician)

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 State Licensed Health Care Professional

_____

State Licensed Health Care Professional Phone Number