# West Point Consolidated School District
# Office of Child Nutrition
# Medical Statement for 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/Disabled Person:_____

Student's Address: _____

_____ Student's Date of Birth: _____

School Attended by Student: _____

## 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 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? _____

_____

_____