



Medical Statement for Students with Special Dietary Needs in Child Nutrition Programs

PART A

Student's Name: _____ Age: _____

School Name: _____ Grade: _____ Classroom: _____

Guardian Name: _____ Phone: _____

1. Does the child have a disability? YES (Answer #2) NO (Answer #3)

If Yes, describe the disability/diagnosis and the major life activity affected by the disability.

2. Does the child have special nutritional or feeding needs that require accommodations within the USDA meal pattern? If yes, complete Part B of this form and have it signed by a health care provider with prescriptive authority or the parent. YES NO

3. Does the child have special nutritional or feeding needs that require accommodations outside the USDA meal pattern? If yes, complete Part B of this form and have it signed by a health care provider with prescriptive authority. YES NO

PART B

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

List any dietary restrictions or special diets: _____

List any allergies or food intolerances to avoid: _____

List allowable food substitutions: _____

List food that needs the following change in texture. If all food needs to be prepared in this manner, indicate "All."

Chopped: _____

Finely Ground: _____

Pureed: _____

Liquid Modifications: Honey/Nectar/Other (specify) _____

List any special equipment or utensils that are needed and any additional comments about the student's eating patterns or dietary modifications: _____

Parent or Guardian: _____ Date: _____

Signature

Physician or Medical Authority: _____ Date: _____

Signature

_____ Phone: _____

Please Print