Medical Statement for Students Requiring Special Meals

Student Name:____Birth Date: _________

School District:____School Year: _______

School:____Grade: ___________

Parent's Name(s): ____

Home Phone:______________Work Phone (father):_______________(mother): ________________

For Physician's Use Only

Identify and describe disability, or medical condition, including allergies that require the student to have a special diet. Describe the major life activities affected by the student's disability/allergy.

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Diet Prescription: (check all that apply)

______ Diabetic (include calorie level or attach meal plan)

______ Reduced Calorie

______ Increase Calorie

_____Modified Texture and/or Liquids

_____Food allergy (describe)

_____Other (describe)

Food Omitted and Substitutions:

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture: _______Regular ______Chopped_________Ground ____Pureed

Indicate Thickness of Liquids:_______Regular_________Nectar _______Honey ____Pudding

Special Feeding Equipment:____

Additional Comments: ____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

____________________	____________________	____________________
Physician's Signature	**Telephone Number**	**Date**

I hereby give my permission for the school staff to follow the above stated nutrition plan.

____________________	____________________
Parent/Guardian	**Date**