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.

____

____

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**