Medical Statement for
Non-Disabled Students With Medical or Other Special Dietary Needs
Requiring Special Foods in Child Nutrition Programs

Part I  To be competed by School District or Parent/Guardian

Date: ________________________________________________________________
Name of Student: ______________________________________________________
School District: _______________________________________________________
School Name: __________________________________________________________

Part II  To be completed by one of the following medical authorities: physician,
physician assistant, registered dietitian, nurse practitioner or registered nurse

Patient’s Name ______________________________________ Age __________
Diagnosis (include description of the patient’s medical or other special dietary needs
that restrict the patient’s diet)
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
List foods to be omitted from diet:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
List foods to be substituted:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Date _______________ Signature of Medical Authority_______________________