

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

Part I To be completed 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 _____