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_____