CHILD NUTRITION
TISHOMINGO CO. SCHOOL DISTRICT

TCSD Office of Child Nutrition
1620 Paul Edmondson Drive, Iuka, MS 38852
(662) 423-3206 (662) 424-9820

Medical Statement for Special Diets

Part I

Date: _____

Name of Student: _____

Name of School District: Tishomingo County School District

School Attended by Student: _____

Part II

Patient Name: _____ **Age:**_____

Diagnosis: _____

_____

List food(s) to be omitted from diet and food(s) that may be substituted: _____

_____

_____

Special Equipment: _____

_____

Part III

Please provide an explanation of how the food impacts the student. Select any symptoms that may occur as a result of eating the specified foods.

☐ Tingling or itching in the mouth ☐ Hives, itching or eczema
☐ Swelling of the lips, face, tongue, and throat or other parts of the body.
☐ Wheezing, nasal congestion or trouble breathing
☐ Abdominal pain, diarrhea, nausea or vomiting
☐ Dizziness, lightheadedness or fainting
☐ Other-Please describe: _____

Provider's Name: _____
Provider's Phone Number: _____

DATE: **SIGNATURE of PHYSICIAN**