NORWICH FREE ACADEMY

Medical Center

Medical Statement for Children without Disabilities
Requiring Special Meals in Child Nutrition Programs

To be completed by licensed care provider (physician, physician assistant, doctor of osteopathy and advanced practice registered nurse):

Student's name: _____ **Date:** _____

Diagnosis:

_____

_____

_____

Describe the medical or other special dietary needs that restrict the child's diet:

_____

_____

List food(s) to be **omitted** from the diet and food(s) to be **substituted** (Attach specific Diet Plan):

_____

_____

_____

_____

List foods that require a change in texture: _____
Cut up or chopped to bite-size pieces: _____
Finely ground:_____
Pureed_____
Special Equipment Needed:_____

_____

_____ _____

Signature of Licensed Care Provider Date