Medical Statement for Special Dietary Needs

Please read page 1 before completing this form.

Student's Name	Student's PIN/ID Number	Age*
Name of School*	**Grade Level***	**Classroom***

*Please include information that is accurate as of the time of this form's submission.

1. How does the child's physical or mental impairment restrict his or her diet?

2. Please complete all of the sections below that are applicable to the child.

Allergies and Celiac Disease	What food(s)/type(s) of food should be omitted? Please be specific.	
	List foods to be substituted. (Avoid specific brand names, if possible.)	
Diabetes Mellitus	Please describe any modifications necessary to accommodate the child's needs.	
Texture Modifications	The child requires that all foods be: ☐ Pureed ☐ Diced/finely ground ☐ Chopped/cut into bite-sized pieces	Liquids should be: ☐ Pudding thick ☐ Honey thick ☐ Nectar thick ☐ Thin/normal consistency
Other	What food(s)/type(s) of food should be omitted? Please be specific.	
	List foods to be substituted.	

3. Additional comments:

Parent's Signature	Date
Parent's Name (Please Print)	Phone Number

Signature Below Required (See section C, page 1)
Please check the appropriate title:

- ☐ Physician
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ Podiatrist
- ☐ Dentist
- ☐ Optometrist

Medical Practitioner's Signature & Date

Medical Practitioner's Name, Title, & Phone Number (Please Print)

This institution is an equal opportunity provider.

Updated 01/17