MEDICAL STATEMENT FOR STUDENT REQUIRING SPECIAL MEALS

Student Name: ______________________ Birth Date: ____________

Parent Name: ______________________ Telephone: ____________

School District: ______________________

School Attended: ______________________ Telephone: ____________

For Physician's Use

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet.
Describe the major life activities affected by the student's disability (see back of form).

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Diet Prescription (check all that apply):

☐ Diabetic (include calorie level or attach meal plan) ☐ Modified Texture and/or Liquids

☐ Reduced Calorie ☐ Food Allergy (describe): ____________

☐ Increased Calorie ☐ Other (describe): ____________

Food Omitted and Substitutions:
Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids:

☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ **Special Feeding Equipment:** ____________

Additional Comments: ____________

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature	Telephone Number	Date
Signature of Preparer or Other Contact	Telephone Number	Date

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian ______________________ Date ____________

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