

ESTACADA SCHOOL DISTRICT
Medical Statement- for Accommodating Disabilities

Submit this form to: Kelley Kubalek/Julie Theander
Site/Provider Name: Nutrition Services Department

Part I To be completed by Parent/Guardian or Sponsor

Name of Participant: _____
Parent/Guardian Name _____ Phone # _____

Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law*. Answer questions 1-3.

<p>1. Describe the major life activity or major bodily function affected by the participant's physical or mental impairment that restricts the diet:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>2. Meal Accommodation Plan (Foods to omit or avoid):</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>3. Foods to be substituted and recommended alternatives (include modification and accommodation)</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Signature of Licensed Health Care Professional*: _____</p> <p>_____ Date _____</p>

Sponsor's use: Accommodation made: _____
Staff Signature _____ Date _____

*Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD)

This institution is an equal opportunity provider