Medical Statement for Children with Disabilities
Requiring Special Meals in Child Nutrition Programs

Date________________________ Name of Child_____________________________

School Attended by Child____

To be filled out by Licensed Physician:
A licensed physician is defined as a doctor of medicine or osteopathy.

Patient's name_____________________________Age______________________

Diagnosis:____
____
____

Describe the patient's disability and the major life activity affected by the disability:____
____
____

Does the disability restrict the individual's diet? Yes No

If yes, 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:____
____

Date______________________ ____________________________________
Signature of Licensed Physician

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