Exhibit 6.3. Medical Statement for Non-Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Non-Disabled Child

Part I (to be completed by School District/School/Organization/Sponsor)
Date_____

Name of School District/School/Organization/Sponsor_____

Name of Student/Individual _____

Address_____

_____Date of Birth_____

School/Provider/Center Name_____

School/Provider/Center Address_____

Part II (to be completed by a Medical Authority)

Patient's Name_____Age_____

Diagnosis_____

_____

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

_____

_____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted_____

_____

_____

Special equipment needed_____

_____

_____

_____ _____
Date Signature of Medical Authority