MEDICAL STATEMENT
For
Children Requiring Special Foods in School Lunch Program

PART I

Name of Student ____________________________________ D.O.B. ____________

Name of Parent/Guardian _________________________ Phone _________________

School Attending ____

PART II (to be completed by physician or nurse practitioner)

Diagnosis (Include description the allergy and history of past reactions):

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____
____

List food(s) to be omitted from the diet:

____
____
____

List food(s) that may be substituted (Diet Plan):

____
____
____
____
____

___________________________________ ______________________________
Physician (print name) Physician's signature

___________________ ___________________________
Date Phone number