

Medical Statement for Student Requiring Special Meals

Name of Student:	School District:
Birth Date:	School Attended:
Parent Name:	Telephone:
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).

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