

**Medical Statement For Children  
With Special Needs In Child Nutrition Programs**

**Student's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**School Name:** \_\_\_\_\_ **Grade Level:** \_\_\_\_\_ **Classroom:** \_\_\_\_\_

**Does the student have a disability that requires the student to have a special diet or feeding equipment/utensils?**  **No**  
 **Yes** If Yes, describe the disability and the major life activity affected by the disability, complete this form, and have it signed by the student's physician. Return it to the school when completed.

Describe the disability/diagnosis: \_\_\_\_\_  
\_\_\_\_\_

**If the student is NOT disabled, does he/she follow a special dietary modification or require assistance in eating?**  
 **No**  **Yes**

Describe the dietary modification or assistance required: \_\_\_\_\_  
\_\_\_\_\_

Diet Prescription: \_\_\_\_\_  
\_\_\_\_\_

List Food Allergies/Intolerances: \_\_\_\_\_  
\_\_\_\_\_

List Allowable Food Substitutions: \_\_\_\_\_  
\_\_\_\_\_

Indicate any texture modifications and which foods need to be modified:

Chopped/Cut up: \_\_\_\_\_

Ground: \_\_\_\_\_

Pureed: \_\_\_\_\_

Liquid Modifications: Honey                  Nectar                  Other (specify)

List special equipment/utensils needed: \_\_\_\_\_  
\_\_\_\_\_

Additional comments about the student's eating patterns or dietary modifications:

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's or Medical Authority's Signature: \_\_\_\_\_ Date: \_\_\_\_\_