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: _____