Medical Statement for
Children with Disabilities
Requiring Special Foods in Child Nutrition Programs

Part I To be competed by School District or Parent/Guardian

Date: _____

Name of Student:_____

School District: _____

School Name: _____

Part II To be completed by Licensed Physician

Patient's Name: _____ Age: _____

Diagnosis (include description of the patient's disability and the major life activity affected by the disability):

_____

_____

_____

_____

Does the disability restrict the patient's diet? Yes _____ No _____

If yes, list how disability restricts diet:

_____

_____

_____

_____

Diet Plan:

Foods to be omitted from diet:

_____

_____

_____

_____

Foods to be substituted (include modifications of texture of consistency that may be necessary):

_____

_____

_____

_____

Date:_____ Signature of Physician: _____