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 leverl 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 names student needs special school meals as described above, due to the student's disability or chronice 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