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).

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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**

Revised 6/99