MEDICAL STATEMENT FOR STUDENT
REQUIRING SPECIAL MEALS

Name of Student:	Date of Birth:
Name of Parent(s):	Telephone:
School District:	School Telephone
School Attending:	

For Completion By Medical Authority: ***Physician (M.D. or D. O.), Physician Assistant, Assistant Physicians or Nurse Practitioners***

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 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.

Medical Authority 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.

Signature of Parent	Date