

**Medical Statement for Student *With* a Disability**  
Requires Special Foods in Child Nutrition Programs

Students Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name of parent/guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of disability: \_\_\_\_\_

Explanation of why disability restricts child's diet: \_\_\_\_\_

\_\_\_\_\_

Major Life activity affected by disability: \_\_\_\_\_

Foods to Omit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Foods to Substitute:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information regarding diet or feeding: (provide additional information below or on back of form or attach this form).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

\_\_\_\_\_  
Physician's Signature

Office Phone Number \_\_\_\_\_ Date: \_\_\_\_\_

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