

MEDICAL STATEMENT FOR STUDENTS REQUIRING SPECIAL MEALS

Student's name _____ **Birth date** _____

School attended _____ **School district** _____

Parent/guardian name _____ **Phone number** _____

1. Identify the disability, or medical condition (diagnosis) that requires a special diet/meal or accommodation?

2. How does the disability restrict the diet?

3. What major life activity is affected?

4. Diet Prescription:

5. List food/type of food to be omitted. A specific list/menu may also be included, for the safety of the child:

6. List food/type of food to be substituted. A specific list/menu may also be included, for the safety of the child:

7. Additional Comments/Concerns:

8. The above named student needs special school meals as described above, due to student's disability or chronic medical condition.

HEALTHCARE PROVIDER'S NAME

DATE

HEALTHCARE PROVIDER'S SIGNATURE

PHONE NUMBER