Medical Statement For Children With Special Needs in Child Nutrition Programs

Student's Name: _____ **Age:** _____

School Name: _____ **Grade Level:** _____ **Classroom:** _____

Does the student have a disability that requires the student to have a special diet or feeding equipment/utensils? ☐ **No** ☐ **Yes**

If Yes, describe the disability and the major life activity affected by the disability, complete this form, and have it signed by the student's physician. Return it to the school when completed.

Describe the disability/diagnosis: _____

If the student is NOT disabled, does he/she follow a special dietary modification or require assistance in eating? ☐ **No** ☐ **Yes**

Describe the dietary modification or assistance required: _____

Diet Prescription: _____

List Food Allergies/Intolerances: _____

List Allowable Food Substitutions: _____

Indicate any texture modifications and which foods need to be modified:

- ☐ Chopped/Cut up: _____
- ☐ Ground: _____
- ☐ Pureed: _____
- ☐ Liquid Modifications: Honey Nectar Other (specify)

List special equipment/utensils needed: _____

Additional comments about the student's eating patterns or dietary modifications: _____

Parent's Signature: _____ Date: _____

Physician's or Medical Authority's Signature: _____ Date: _____