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

Student’s 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 to 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: ____________________________

MDU/August 2001
Reviewed 8/2007