

**Medical Statement for Children *without* Disabilities
Requiring Special Meals in Child Nutrition Programs**

Part I *(To be filled out by School)*

Date: _____ Name of Child: _____

School Attended by Child: _____

Part II *(To be filled out by Medical Authority)*

Patient's Name: _____ Age: _____

Diagnosis: _____

Describe the medical or other special dietary needs that restrict the child's diet:

List food(s) to be **omitted** from the diet and food(s) to be **substituted** (Diet Plan):

List foods that require a change in texture:

Cut up or chopped to bite-size pieces: _____

Finely ground: _____

Pureed: _____

Special Equipment Needed: _____

Date _____ Signature of Medical Authority _____

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**Medical Statement for Children *with* Disabilities
Requiring Special Meals in Child Nutrition Programs**

Part I (To be filled out by School)

Date: _____ Name of Child: _____

School Attended by Child: _____

Part II (To be filled out by Physician)

Patient's Name: _____ Age: _____

Diagnosis: _____

Describe the patient's disability and the major life activity affected by the disability:

Does the disability restrict the individual's diet? Yes No
If yes, list food(s) to be **omitted** from the diet and food(s) to be **substituted** (Diet Plan):

List foods that require a change in texture:

Cut up or chopped to bite-size pieces: _____

Finely ground: _____

Pureed: _____

Special Equipment Needed: _____

Date

Signature of Physician

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