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 _____