

**MEDICAL STATEMENT
FOR
CHILDREN *WITHOUT* DISABILITIES
Requesting Special Foods in Child Nutrition Programs**

Part I (to be filled out by SFA or Parent/Guardian)

Name of Student: _____ Age: _____

Name of Parent/Guardian: _____ Telephone Number: _____

School District: _____ School Attended by Student: _____

Part II (to be filled out by a recognized Medical Authority)

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the child's diet):

List food(s) to be omitted from diet:

List food(s) that may be substituted (diet plan):

Additional information:

Date

Signature of Recognized Medical Authority

Telephone Number: _____