

**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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