MEDICAL STATEMENT
For Children with Disabilities Requiring Special Needs
in Child Nutrition Programs

PART I (to be filled out by School District)

Name of Student _____ Date _____

School District _____

School Attended by Student _____

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) that may be substituted (Diet Plan):

_____

_____

Special Equipment: _____

_____

Date: _____ Signature of Physician: _____

*Note: Lactose reduced milk shall be made available upon receipt of a written request from any parent of a student who is lactose intolerant.