

# MEDICAL STATEMENT

## 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):

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List food(s) to be omitted from diet:

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

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Additional information:

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Recognized Medical Authority

\_\_\_\_\_  
Medical Authority Telephone Number