TUSCUMBIA CITY SCHOOLS
MEDICAL STATEMENT FOR SPECIAL NEEDS DIET

Part I

Date: _____

Name of Student: _____

School Attended by Student: _____

**Part II (To be completed by physician)

Patient's Name: _____ Age: _____

Diagnosis:

_____

_____

Does the disability restrict the individual's diet? Yes _____ No _____

Diet Prescription (Check all that apply. Please submit diet instruction sheets.)

☐ Diabetic ☐ Reduced Calorie

☐ Increased Calorie ☐ Modified Texture

☐ Other (DESCRIBE) _____

Duration of Restriction: _____

Foods Omitted and Substitutions (Please check food groups to be omitted.)

☐ Meat and Meat Alternates ☐ Milk and Milk Products

☐ Bread and Cereal Products ☐ Fruits and Vegetables

Textures Allowed (Check the allowed texture.)

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Other Information Regarding Diet or Feeding (Please provide additional information on the back of this form or attach to this form.)

_____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____ _____ _____

Physician/Recognized Medical Authority Signature Office Phone Number Date