## Medical Statement for Student Requiring Special Meals

Name of Student:	School District:	
Birth Date:	School Attended:	
Parent Name:	Telephone:	
Telephone:	*	
3		
For Physician's Use	*	
	ion, including allergies that requires the student to	
pecial diet. Describe the major life activities aff	fected by the student's disability (see back of form	1).
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	s	
Oiot Propagation (shools all that and ).	ts	8
Diet Prescription (check all that apply):  Diabetic (include calorie level or attach meal	plan) Modified Texture and/or Liquids	
Reduced Calorie Food Allergy (descri		
Increased Calorie Other (describe):—		_
,	70 m	
Food Omitted and Substitutions:		
Jse space to list specific food(s) to be omitted as	nd food(s) that may be substituted. You may atta	ch an
dditional sheet if necessary.	* =	
×		553
OMITTED FOODS	SUBSTITUTIONS	
	The second secon	
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	3	
Indicate Texture:  Regular Chopped Ground	d Down and	
Regular Chopped Ground	d Pureed	
Indicate thickness of liquids:		
Regular Nectar Honey	Pudding	
		. 70
Special Feeding Equipment	11	
: <del></del>		/
Additional comments:		
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	cial school meals as described above, due to the	student'
disability or chronic medical condition.	9	
Dhysician's Cignature	Tolonhous Number Date	
Physician's Signature	Telephone Number Date	
Signature of Preparer or Other Contact	Telephone Number Date	
- Contact	The state of the s	
I hereby give my permission for the school staff	to follow the above stated nutrition plan.	
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Parent/Guardian	Date	