Medical Statement for Student With a Disability
Requires Special Foods in Child Nutrition Programs

Student’s Name: ___________________________________________________   Age: _____   Grade: _____
Name of parent/guardian: ___________________________________________   Phone #: __________________
Name of disability: ___________________________________________________________________________
Explanation of why disability restricts child’s diet: ___________________________________________________
_________________________________________________________________________________
Major life activity affected by disability: __________________________________________
Foods to Omit: 

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
Foods to Substitute:

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Other information regarding diet or feeding: (provide additional information below or on back of 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’s Signature

Office Phone Number: _____________________________       Date: _____________________________

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