Medical Statement for Student Without a Disability
Requesting Special Foods in Child Nutrition Programs

Student’s Name: ___________________________________________________   Age: _____   Grade: _____

Name of parent/guardian: __________________________   Phone #: ___________________

Description of child’s medical or other special dietary needs that restrict the child’s diet:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

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).
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Signature of Medical Authority

Office Phone Number: ____________________________   Date: ____________________________

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