

## **Medical Statement for Students with Special Dietary Needs in Child Nutrition Programs**

Student's Name:				PART A		
Phone:	Student's Name:				Age:	
1. Does the child have a disability?	School Name:			Grade:	Classroom:	
2. Does the child have special nutritional or feeding needs that require accommodations within the USDA meal pattern? If yes, complete Part B of this form and have it signed by a health care provider with prescriptive authority or the parent. YES NO  3. Does the child have special nutritional or feeding needs that require accommodations outside the USD meal pattern? If yes, complete Part B of this form and have it signed by a health care provider with prescriptive authority. YES NO  PART B  Diet Prescriptive authority. YES NO  PART B  Diet Prescription: (use back of form if more space is needed)  List any allergies or food intolerances to avoid:  List any allergies or food intolerances to avoid:  List allowable food substitutions:  List food that needs the following change in texture. If all food needs to be prepared in this manner, indicate "All." Chopped:    Finely Ground:	Guardian	Name:			Phone:	
meal pattern? If yes, complete Part B of this form and have it signed by a health care provider with prescriptive authority or the parent.	1.		-			ability.
meal pattern? If yes, complete Part B of this form and have it signed by a health care provider with prescriptive authority.  PART B  Diet Prescription: (use back of form if more space is needed)  List any dietary restrictions or special diets:  List any allergies or food intolerances to avoid:  List allowable food substitutions:  List food that needs the following change in texture. If all food needs to be prepared in this manner, indicate "All."    Chopped:   Finely Ground:   Pureed:   Diety Ground:   D	2.	meal pattern? If	yes, complete Part B	of this form and have i	t signed by a <u>health care p</u>	·
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□ Pureed: □ Liquid Modifications: Honey/Nectar/Other (specify) List any special equipment or utensils that are needed and any additional comments about the student's eating patterns or dietary modifications:  □ Parent or Guardian: □ Date: □ Signature  Physician or Medical Authority: □ Signature  Date: □ Signature		al.				indicate "All."
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Special Dietary Needs 7/2018