

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

Students Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name of parent/guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Description of chld's medical or other special dietary needs that restrict the child's diet:

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Foods to Omit:

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Foods to Substitute:

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Other information regarding diet or feeding: (provide additional information below or on back of form or attach this form).

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Signature of Medical Authority \_\_\_\_\_

Office Phone Number \_\_\_\_\_ Date: \_\_\_\_\_

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