Medical Statement for Students Requiring Special MealsThis statement must be updated when there is a change in the diet order.

Name of Student:	Student's Birth Date:	
Parent Name:	Student's Grade:	
Parent Telephone:	School District and So	chool Attended:
For Physician's Use	Juding allergies that require the	he student to have a special diet
Identify and describe disability, or medical condition, including allergies that require the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).		
Diet Prescription (check all that apply):		
Diabetic: calorie level (attach meal plan) Modified Texture and/or Liquids		
Calorie-Controlled: calorie level Other (describe):		
Is this a life-threatening allergy? Yes ☐ No ☐		
☐ Student may select their meals from regular foods provided at school. ☐ Parent may review menu in advance and select the child's meals from regular foods provided at school.		
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Food(s) Omitted and Substitutions: Use space to list specific food(s) to be omitted and food(s) that may be substituted. Attach an additional sheet if necessary.		
Substitutions are considered optional unless checked.	(3) that may be substituted. 7	attach an additional sheet ii ricoessary.
Foods to be Omitted Su	ubstitutions	Required
Foods to be Offitted St	ibstitutions	Required
		-
Indicate Texture: Regular Chopped	Ground Pureed	
Indicate thickness of liquids: ☐ Regular ☐ Nect		ling
Special Feeding Equipment		
Additional comments:		
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I certify that the above named student needs special sci medical condition.	nool meals as described abov	7e, due to the student's disability of chronic
Physician's Signature	Telephone Number	Date
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Signature of Preparer or Other Contact	Telephone Number	Date
I hereby give my permission for the school staff to follow the above stated nutrition plan.		
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Parent/Guardian	 Date	
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