

## Medical Statement for Children Requiring Special Meals

Name of Student:	School District:	
Birth Date:	Grade:	
Parent Name:	School Attended:	
Telephone:	Telephone:	
<b>For Physician's Use</b>		
Identify and describe disability or medical condition, including allergies, that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).		
<b>Diet Prescription (check all that apply):</b> <input type="checkbox"/> Diabetic (include calorie level, carbohydrate count, and/or attach meal plan): _____ <input type="checkbox"/> Modified Texture and/or Liquids <input type="checkbox"/> Food Allergy (list): _____ <input type="checkbox"/> Reduced Calorie: _____ <input type="checkbox"/> Increased Calorie: _____ <input type="checkbox"/> Other (describe e.g. PKU, Ketogenic, Tube Feeding): _____		
<b>Food Omitted and Substitutions:</b> Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary. Describe in detail allergies e.g. milk allergy - does that include pudding, cheese, yogurt, etc.		
<b>OMITTED FOODS</b>	<b>SUBSTITUTIONS</b>	
<b>Indicate Texture (see attached sheet for additional information):</b> <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed <b>Indicate thickness of liquids:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Nectar <input type="checkbox"/> Honey <input type="checkbox"/> Pudding <input type="checkbox"/> Special Feeding Equipment _____		
Additional comments: _____		
<i>I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.</i>		
Physician's Signature	Telephone Number	Date
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.		
Parent/Guardian	Date	

## EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

PART A			
Student's Name		Age	
Name of School		Grade Level	Classroom
Does the child have a disability? If Yes, describe the major life activities affected by the disability.		Yes	No
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.		Yes	No
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.		Yes	No
If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.			
PART B			
List any dietary restrictions or special diet.			
List any allergies or food intolerances to avoid.			
List foods to be substituted.			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."			
Cut up or chopped into bite size pieces:			
Finely ground:			
Pureed:			
List any special equipment or utensils that are needed.			
Indicate any other comments about the child's eating or feeding patterns.			
Parent's Signature		Date:	
Physician or Medical Authority's Signature		Date:	