☐ Student Office File
☐ Student Medical File
☐ Food Services File

Medical Statement for Student Requiring Special Meals *(2019/2020)*

Student Last Name, First Name _____ **Birth Date** _____ **Grade** _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL
(please print clearly)

Identify and describe medical condition, including allergies that require the student to have a special diet. Describe the major life activities affected by the student's medical condition.

_____
_____
_____

Nutrition Prescription (check all that apply):

☐ Diabetic (include calorie level or attach meal plan)
☐ Reduced Calorie
☐ Food Allergy (describe): _____
(Please complete a Food Allergy Assessment Form in the main office.)
☐ Other (describe): _____
☐ Modified Texture and/or Liquids
☐ Increased Calorie

Food Omitted and Substitutions:

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.

OMITTED FOODS	**SUBSTITUTIONS**

Indicate Texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed
Indicate thickness of liquids: ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding
Special Feeding Equipment: _____
Additional comments: _____

I certify that the above-named student needs special school meals as described above, due to the student's disability or chronic medical condition.

_____ _____
Signature of Licensed Health Professional (LHP) Date of Signature

_____ _____
Print Name of Licensed Health Professional (LHP) Telephone Number

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Signature of both Parents/Custodial Parent/Guardian **Date of Signature**

_____ _____
_____ _____

Telephone Numbers:	**HOME**	**WORK**	**CELL**
Mother/Guardian	_____	_____	_____
Father	_____	_____	_____