
Exhibit 6.1. Medical Statement for Disabled Child

**Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Disabled Child**

Part I (to be completed by School District/School/Organization/Sponsor)

Date _____

Name of School District/School/Organization/Sponsor _____

Name of Student/Disabled Person _____

Address _____

_____ Date of Birth _____

School/Provider/Center Name _____

School/Provider/Center Address _____

Part II (to be completed by the Physician)

Patient's Name _____ Age _____

Diagnosis _____

Describe the individual's disability and the major life activity affected by the disability _____

Does the disability restrict the individual's diet? Yes _____ No _____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted _____

Special equipment needed _____

_____ Date

_____ Signature of Physician