Medical Statement/Diet Prescription
Children with Disabilities Requiring Special Nutrition Services in Child Nutrition Programs (567-1222)

Part 1 (to be filled out by local education agency or parent)
Date:_____ Name of Student:_____
LEA_____ School Attended by Student_____

Part 2 (to be filled out by Physician)
Diagnosis_____

Describe the patient's disability and the major life activity affected by the disability_____

Does the handicap restrict the patient's diet?_____

Diet Prescription (check all that apply)
Diabetic____ Reduced Calorie_____
Increased Calorie_____ Modified Texture_____
Other (describe)_____

Foods To Be Omitted _____
_____

Foods To Be Substituted _____

Textures Allowed (Check the allowed texture.)
Regular____ Chopped____ Ground____ Pureed____

Other Information Regarding Diet or Feeding (Please provide additional information on the back of this form or attach to this form.)

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition, and the parent has the right to discontinue this at any time by signing the date stopped line.

_____ _____ _____
Physician/Recognized Medical Authority Phone # Date

_____ _____ _____
Parents Signature to Discontinue Diet Phone # Date