Exhibit 6.1. Medical Statement for a Disabled Child

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

PART I (to be completed by school district/organization/sponsor)

Date: _____

Name of School District/School/Organization/Sponsor _____

Name of Student/Individual _____

Address _____

Date of Birth _____

School/Provider/Center Name _____

School/Provider/Center Address _____

PART II (to be completed by a physician)

Patients Name_____ Age _____

Diagnosis _____

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

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

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

Special equipment needed

Date _____ Signature of Physician _____