Exhibit 6.1. Medical Statement for a Non-Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for a Non-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 medical authority)

Patients Name_____ Age _____

Diagnosis _____

Describe the medical or other special dietary needs that restricts the child's diet

List the food(s) that should be omitted from the child's diet and food(s) that may be substituted based on the answer given above

Special equipment needed

Date _____

Signature of Medical Authority _____