MEDICAL STATEMENT FOR STUDENT REQUIRING MEAL MODIFICATION

Name of Student	Date of Birth
Name of Parent/Guardian	Parent/Guardian Contact Phone
Local Education Agency	School Attending

For Completion By Medical Authority: *Physician (M.D. or D.O.), Physician's Assistant, Assistant Physician or Nurse Practitioner*

Identify the child's physical or mental impairment and how it restricts the child's diet, including allergies, requiring the student to have a modified diet.

Explanation of what must be done to accommodate the child.

Omitted Foods Listed Below	Substitute Foods Listed Below	
Medical Authority Printed Name	Title	
Medical Authority Signature	Telephone Number	Date

Parent/Guardian Permission: *To be completed by a parent/guardian*

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Signature of Parent/Guardian	Date