Medical Statement for Special Dietary Needs

Students Name________________________ **Student ID Number_____________**

1. **How does the child's Physical or mental impairment restrict his or her diet?**

2. **Please complete all of the sections below that are applicable to the child.**

What food(s)/type of food should be omitted? Please be specific.___________________________________

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List foods to be substituted. ____

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Please describe any modifications necessary to accommodate the child's needs.

The child requires that all foods be: (please circle)

Pureed Diced/Finely Ground Chopped/Cut into Bite-Sized Pieces

The child requires liquids should be: (please circle)

Pudding Thick Honey Thick Nectar Thick Thin/Normal Consistency

Additional Comments:

Parent's Signature______________________________ Date__________________________

Parent's Name (Print)____________________________ Phone Number_________________

Healthcare Provider (with prescription privileges) Signature and Date

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Healthcare Provider's Name, Title, Phone Number (please print)

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