Medical Statement for Student *With* a Disability (Life Threatening)

Requires Special Foods in Child Nutrition Programs

Student's Name: _____ Age: _____ Grade: _____

School_____

Name of parent/guardian: _____ Phone Number: _____

Name of disability: _____

Explanation of why disability restricts child's diet: _____

_____

Major life activity affected by disability: _____

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other information regarding diet or feeding: (provide additional information below or on back of 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.

_____

Physician's Signature

Office Phone Number: _____ Date: _____

MDE/August 2001
Reviewed 8/2007