

**Medical Statement for Children *without* Disabilities
Requiring Special Meals in Child Nutrition Programs**

Part I (To be filled out by School)

Date: _____ Name of Child: _____
School Attended by Child: _____

Part II (To be filled out by Medical Authority)

Patient's Name: _____ Age: _____

Diagnosis: _____

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

List food(s) to be omitted from the diet and food(s) to be substituted (Diet Plan):

List foods that require a change in texture:
Cut up or chopped to bite-size pieces: _____
Finely ground: _____
Pureed: _____

Special Equipment Needed:

Date _____ Signature of Medical Authority _____

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