Medical Statement for Student Requiring Special Meals

Due to Food Allergy or Intolerance

Student Name:	District/School: Willard Public Schools
Birth Date:	School Contact Name:
Parent Name:	School Attending:
Address:	School Telephone:
Telephone:	

For Physician's Use

Identify and describe disability or medical condition, including allergies that requires he student to have a special diet.

_____

_____

_____

Diet Prescription (check all that apply)

❑ Food Allergy (describe): _____ Diabetic_____ Modified Texture and/or Liquids_____

❑ Reduced/Increased Calories_____Other (describe):_____

Omitted Foods and Substitutions:

List the specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

Omitted Foods	Substitutions
_____	_____
_____	_____
_____	_____

Indicate Texture:

Regular____ Chopped____ Ground____ Pureed_____

Indicate Thickness of liquids:

Regular____ Nectar____ Honey____ Pudding____

Special Feeding Equipment_____

Additional Comments: _____

_____

I certify that the above named student needs special school meals as described above due to the student's disability or chronic medical condition.

Physicians Signature Phone Number Date

I hereby give permission for the school staff to follow the above stated nutrition plan.

_____ _____

Parent/Guardian Signature Date