

**MEDICAL STATEMENT
FOR CHILDREN WITH DISABILITIES
IN CHILD NUTRITION PROGRAMS**

PART I

Date _____
Child's Name _____ Age _____
School District _____ School _____

PART II (To Be Completed By Physician)

Diagnosis: _____
Describe the child's disability and the major life activity affected by the disability: _____ _____
Does the disability restrict the child's diet? Yes _____ No _____
List dietary restrictions or special diet: _____ _____
List allergies or food intolerances: _____ _____
List foods that require a change in texture: _____ _____
List required special equipment: _____ _____
Date _____ Signature of Physician _____

PART III (Parent/Guardian Signature)

Date _____ Signature of Parent/Guardian _____

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Children with food allergies or intolerances do not, generally, have a disability as defined under 7 CFR 15b.3. School food authorities may, but are not required to, make substitutions for them.

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