

**Medical Statement for Student *Without* a Disability**  
Requesting Special Foods in Child Nutrition Programs

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of parent/guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

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Foods to Omit:

Foods to Substitute:

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Other information regarding diet or feeding: (provide additional information below or on back of form or attach to this form).

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Signature of Medical Authority

Office Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_