**Medical Statement for Special Dietary Needs**

**Students Name_____ Student ID Number_____**

1. **How does the child's Physical or mental impairment restrict his or her diet?**

2. **Please complete all of the sections below that are applicable to the child.**

What food(s)/type of food should be omitted? Please be specific._____

_____

List foods to be substituted. _____

_____

Please describe any modifications necessary to accommodate the child's needs.

**The child requires that all foods be: (please circle)**

Pureed Diced/Finely Ground Chopped/Cut into Bite-Sized Pieces

**The child requires liquids should be: (please circle)**

Pudding Thick Honey Thick Nectar Thick Thin/Normal Consistency

Additional Comments:

Parent's Signature_____ Date_____

Parent's Name (Print)_____ Phone Number_____

**Healthcare Provider (with prescription privileges) Signature and Date**

_____

**Healthcare Provider's Name, Title, Phone Number (please print)**

_____