Physician's Statement for Students with Special Dietary Needs*

Student's Name	Age

Name of School	Grade Level	Classroom

Does the child have a disability? If Yes, describe the major life activities affected by the disability.	Yes	No
Does the child have special nutritional or feeding needs? If **Yes**, complete **Part B** of this form and have it signed by a licensed physician.	Yes	No
If the child is not disabled, does the child have special nutritional or feeding needs? If **Yes**, complete **Part B** of this form and have it signed by a recognized medical authority.	Yes	No

PART B

List any dietary restrictions or special diet.

List any allergies or food intolerances to avoid.

List foods to be substituted.

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up or chopped into bite size pieces:

Finely ground:

Pureed:

List any special equipment or utensils that are needed.

Indicate any other comments about the child's eating or feeding patterns.

Physician or Medical Authority's Signature	Date:

***This statement must be updated annually.**