Medical Statement for Children *with* Disabilities Requiring Special Meals in Child Nutrition Programs

Part I (*To be filled out by School*)

Date: ______________________________ Name of Child:_________________________________
School Attended by Child: ____

Part II (*To be filled out by Medical Authority*)

Patient's Name: ____ Age: ____________

Diagnosis: ____
____
____
____

Describe the patient's disability and the major life activity affected by the disability:
____
____

Does the disability restrict the individual's diet? ☐ Yes ☐ No
If yes, list food(s) to be **omitted** from the diet and food(s) to be substituted (Diet Plan):
____
____
____
____
____

List foods that require a change in texture:
Cut up or chopped to bite-size pieces: ____
Finely ground: ____
Pureed: ____

***Special Equipment Needed*:**
____
____

Date ___________________ Signature of Medical Authority _________________________________

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Connecticut State Department of Education, April 2004

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