MEDICAL STATEMENT FOR STUDENT WITH ALLERGIES/ CHRONIC DISEASES/DISABILITIES REQUIRING SPECIAL MEALS

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
CHILD NUTRITION AND FOOD DISTRIBUTION PROGRAMS
(Rev. 6/02) G/Tools/SNP/Medical Statement for Student with Allergies

Name of Student:	School District:
DOB:	School Attended:
Parent Name:	Telephone:
Telephone:	

Diagnosis (i.e., food allergy or chronic disease or disability)
If a disability, describe the major life activity affected by the disability
Diet Prescription and/or Texture and Liquids Modification (Describe in detail to ensure proper implementation and compliance.)
Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed
Indicate thickness of liquids: ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

List foods to be omitted from the diet and foods that may be substituted (may use the back of this form)

Omitted Food	Suggested Substitution
Omitted Food	Suggested Substitution
Omitted Food	Suggested Substitution
Special Feeding Equipment	

Signature of Physician	Printed Name
Telephone	Date
Signature of Preparer or Other Contact	Printed Name
Telephone	Date