



Medical Statement

For Children Without Disabilities Requesting Special Needs in School Nutrition Programs

Part I (To be filled out by the School)

Date _____

Student's Name _____

School Student Attends _____

Please Return Completed Form to the School Cafeteria Manager

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

Patient's Name _____ Age _____

Diagnosis: _____

Describe the medical or other special dietary need that restricts the child's die:

List food(s) to be omitted from diet and food(s) that may be substituted (Diet Plan):

Special Equipment:

Signature of Medical Authority _____

Date _____

Clarksville-Montgomery County School System
School Nutrition Department