MEDICAL STATEMENT
FOR
CHILDREN WITHOUT DISABILITIES
Requesting Special Foods in Child Nutrition Programs

Part I (to be filled out by SFA or Parent/Guardian)

Name of Student: ___________________________ Age: ___________________________

Name of Parent/Guardian: __________________ Telephone Number: __________________

School District: ___________________________ School Attended by Student: __________

Part II (to be filled out by a recognized Medical Authority)

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the child's diet):

________________________________________________________________________

________________________________________________________________________

List food(s) to be omitted from diet:

________________________________________________________________________

________________________________________________________________________

List food(s) that may be substituted (diet plan):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Additional information:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Date ___________________________ Signature of Recognized Medical Authority

Telephone Number: _________________________

Oklahoma State Department of Education Cafeteria Managers' Training Section, July 2016