

**Medical Statement for Children without 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 Recognized Medical Authority\*)**

\*A "recognized medical authority" is a professional recognized by the State of Connecticut Department of Public Health and includes physicians, physician assistants, doctors of osteopathy, and advanced practice registered nurses (APRN).

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Describe the medical or other special dietary needs that restrict the child's diet:

\_\_\_\_\_

\_\_\_\_\_

List food (s) to be **omitted** from the diet and food(s) to be **substituted** (Attach *specific* Diet Plan):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cultural Restrictions:

\_\_\_\_\_

\_\_\_\_\_

Vegetarian please allow:

\_\_\_\_\_

\_\_\_\_\_

Check what is applicable:

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> No Egg     | <input type="checkbox"/> No meat of any kind | <input type="checkbox"/> Tuna is ok    |
| <input type="checkbox"/> Fish is ok | <input type="checkbox"/> Turkey is ok        | <input type="checkbox"/> Chicken is ok |

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature & Address/Stamp  
of Medical Authority

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