

**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 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 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**:

List foods that require a change in texture:

Pureed:

Special Equipment Needed:

Vegetarian/ Cultural Restrictions please allow:

Check what is applicable:

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

Date

Date

Parent Signature

Signature & Address/Stamp
of Medical Authority

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