



Medical Statement

A licensed healthcare professional who is authorized to write medical prescriptions under state law (physician, physician's assistant, nurse practitioner) or registered dietitian must complete parts 2 and 3 of this form. The child's parent or guardian must complete part 1.

PART 1: GENERAL INFORMATION - Completed by Parent/Guardian	
Child's First and Last Name: _____	Date of Birth: _____
Name of Center/Care Provider: _____	
Name of Parent or Guardian: _____	Phone Number: _____

PART 2: ACCOMODATIONS - Completed by Licensed Healthcare Professional or Registered Dietitian					
How does the participant's physical or mental impairment restrict their diet? _____ _____					
What food(s)/type of food(s) must be omitted from the diet? Please be specific: _____ _____					
List food(s)/type of food(s) to be substituted: Please be specific: _____ _____					
Texture Modification (if needed): Check box to the left of modification required <input type="checkbox"/> Pureed <input type="checkbox"/> Ground <input type="checkbox"/> Bite-sized Pieces <input type="checkbox"/> Other, please specify: _____					
Please check if applicable:					
<table border="1"><tr><th>Dairy/Lactose</th><th>Eggs</th></tr><tr><td><input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Dairy Allergy</td><td>If eggs or whole eggs are listed as an allergy for the child, but stated can be cooked in or prepared with, Can the child consume the following:</td></tr></table>	Dairy/Lactose	Eggs	<input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Dairy Allergy	If eggs or whole eggs are listed as an allergy for the child, but stated can be cooked in or prepared with, Can the child consume the following:	
Dairy/Lactose	Eggs				
<input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Dairy Allergy	If eggs or whole eggs are listed as an allergy for the child, but stated can be cooked in or prepared with, Can the child consume the following:				
Can child consume the following:					
Milk/dairy products in baked goods: <input type="checkbox"/> Yes <input type="checkbox"/> No	Breads containing eggs: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Milk/dairy products in entrée items: <input type="checkbox"/> Yes <input type="checkbox"/> No	French toast, pancakes, muffins: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Yogurt: <input type="checkbox"/> Yes <input type="checkbox"/> No	Foods containing mayonnaise: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Cheese: <input type="checkbox"/> Yes <input type="checkbox"/> No					

PART 3: SIGNATURE - Completed by Licensed Healthcare Professional or Registered Dietitian	
Name of Provider/Dietitian: _____	Phone Number: _____
Facility/Office Name: _____	
Facility/Office Address: _____	
Signature: _____	Date: _____