

FORT ZUMWALT SCHOOL DISTRICT

Medical Statement for Student Requiring Special Meals

Name of Student: _____	School District: Fort Zumwalt
Date of Birth: _____	Attendance School: _____
Parent Name: _____	Telephone: _____
Telephone: _____	

For Physician's Use
 Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet. Describe the major life activities affected by the student's disability.

Diabetic (include calorie level or attach meal plan): _____

Reduced Calorie: _____

Increased Calorie: _____

Food Allergy (describe): _____

Other (describe): _____

Food Omitted and Substitutions:
 Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary

OMITTED FOODS	SUBSTITUTIONS

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

_____ Physician's Signature	_____ Telephone Number	_____ Date
_____ Signature of Preparer or Other Contact	_____ Telephone Number	_____ Date

I hereby give my permission for the school staff to follow the above stated nutrition plan.

_____ Parent/Guardian	_____ Date
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