

**SPECIAL DIETARY NEEDS  
PHYSICIAN'S MEDICAL STATEMENT**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Does this patient have a medical condition/disability that affects her/his diet? Yes or No

Did you refer this patient to a dietitian for diet consultation? Yes or No

If yes, please indicate the consulting dietitian: Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Diagnosis or Medical Condition \_\_\_\_\_

**PLEASE MARK ALL AREAS BELOW THAT APPLY, SIGN AND DATE.**

<b>DIET RESTRICTIONS</b>	<b>Day Total</b>	<b>Breakfast</b>	<b>Lunch</b>	<b>Snack</b>
Caloric Requirements	1200	_____	_____	_____
	1500	_____	_____	_____
	1800	_____	_____	_____
	2000	_____	_____	_____
Other (Specify Calories)	_____	_____	_____	_____
Carbohydrate Counting (Specify Grams)	_____	_____	_____	_____

Sodium Restriction (Specify Milligrams): \_\_\_\_\_

Fat Restriction \_\_\_\_\_

Cholesterol Restriction \_\_\_\_\_

Other Restrictions \_\_\_\_\_

**FOOD ALLERGIES**

Food(s) Patient Can Not Have

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SUBSTITUTIONS**

Substitutions Must Be Listed

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TEXTURE CONSISTENCIES**

Solids

Regular Chopped \_\_\_\_\_

Mechanical Soft  
with ground meat \_\_\_\_\_

Mechanical Soft  
with chopped meat \_\_\_\_\_

Pureed \_\_\_\_\_

Liquids

Regular \_\_\_\_\_

Nectar/Syrup \_\_\_\_\_

Honey \_\_\_\_\_

Pudding \_\_\_\_\_

**NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE**

Please specify amount and frequency of feeding

Oral Feedings \_\_\_\_\_

Section 504 of the Rehabilitation Act of 1973 assures disabled individuals' access to meals. If an individual has a disabling condition that limits one or more major life activities and requires a special diet, a physician's statement is required. An updated physician's medical statement must be provided at the beginning of each new school year or when any change is prescribed. Schools or sites may make substitutions for non-disabled individuals who are unable to consume the regular meal because of medical or other special dietary needs. A statement from a recognized medical authority, e.g., a medical doctor (MD), doctor of osteopathic medicine (DO), registered nurse (RN), physician's assistant (PA), certified diabetes educator (CDE), nurse practitioner (RNC) or registered dietitian (RD) is required.

\_\_\_\_\_  
Name & Title (print) Signature Date

Phone Number \_\_\_\_\_