Exhibit 6.1 Medical Statement for Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Disabled Child

Part I (to be completed by School District/School/Organization/Sponsor)
Date ________________

Name of School District/School/Organization Sponsor ________________________________

Name of Student/Disabled Person____

Address ____

____Date of Birth _____________________

School/Provider/Center Name ____

School/Provider/Center Address ____

Part II (to be completed by a Physician)

Patient's Name ____Age ___________

Diagnosis ____

____

Describe the individual's disability and the major life activity affected by the disability _______

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Does the disability restrict the individual's diet? Yes ___ No ___

If yes, list food (s) to be omitted from diet and food (s) that may be substituted ______________

____

Milk Allergy ______ Lactose Intolerance _____ Other ___________________

Special equipment needed ____

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_______________ ____

Date Signature of Physician