Exhibit 6.3 Medical Statement for Non-Disabled Child

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

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

Name of School District/School/Organization Sponsor _____

Name of Student/Individual _____

Address _____

_____Date of Birth _____

School/Provider/Center Name _____

School/Provider/Center Address _____

Part II (to be completed by a Medical Authority)

Patient's Name _____Age _____

Diagnosis _____

_____

Describe the medical or other special dietary needs that restrict the child's diet _____

___Milk Allergy _____

___Lactose Intolerance _____

___ Other _____

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

_____

Special equipment needed _____

_____

_____ _____
Date Signature of Medical Authority