The Ohio Department of Education Division of Food Service
Medical Statement
For
Children Requiring Special Nutritional Needs
In Child Nutrition Programs

PART I (to be filled out by Parent/Guardian)

Name of Student____

School District____

School Attended by Student____

Date:______________________ Signature of Parent/Guardian_______________________________________
Phone Number ________________________

PART II (to be filled out by Physician/Health Provider)

Patient's Name____D.O.B.________________

Diagnosis:____

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Describe the patient's nutritional need:____

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Does the nutritional need restrict the student's diet? Yes______ No______
If yes, list food(s) to be omitted from the diet and food(s) that may be substituted:

Diet Plan

____

____

____

Special Equipment:____

Date:______________________ Signature of Physician____
Phone Number ________________________

*** Please complete all information needed on the form. Incomplete forms cannot be processed. Thank You*

Kings Local School District

Phone: (513) 398-8050

Fax: (Food Service) - (513) 336-0494

Original to Building Nurse
Copy to Food Service Director

This institution is an equal opportunity provider