CHILD NUTRITION

Medical Statement for Children

Requiring Special Meals in Child Nutrition Program

ATTENTION MEDICAL STAFF: PLEASE FAX THIS FORM TO 918-684-3766

<u>Part 1</u> (to be filled out by Parent/Guardian)

Name of Student: _____ **DOB:** _____

Name of Parent/Guardian: _____ **Phone Number:** _____

I hereby authorize the school district staff members to disclose my child's protected health information to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child. I understand that if there are ANY changes, ex: change in diet order from medical authority or my child transfers schools within the district, it is my responsibility to alert the proper school officials of the changes.

Parent/Guardian Signature: _____ Date: _____

<u>Part II</u> (to be filled out by a recognized Medical Authority)

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the child's diet):

_____

_____

_____

List food(s) to be omitted from diet:

_____

_____

List food(s) that may be substituted (diet plan):

_____

_____

List foods that require a change in texture. (Cut up or chopped to bite-size pieces, finely ground or pureed) If all foods need to be prepared in this manner, indicate. "All"

_____

_____

_____

***For Questions please contact: Karah Lehman, Child Nutrition Services 918-684-3765**

_____ _____ _____

Signature of Recognized Medical Authority **Phone Number** **Date**