

Medical Statement for Children

Requiring Special Meals in Child Nutrition Program

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

Part 1 (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 the extent necessary for the protection, prevention child. I understand that if there are ANY changes, ex transfers schools within the district, it is my respons	of an allergic reaction, or emerger c: change in diet order from medic	ncy treatment of my cal authority or my child
Parent/Guardian Signature:	Date:	
Part II (to be filled out by a recognized Medical Aut Diagnosis (include description of the patient's medical or		ict 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 If all foods need to be prepared in this manner, ind	•	nely ground or pureed)
*For Questions please contact: Karah Lehman, Chi	ld Nutrition Services 918-684-376	5
Signature of Recognized Medical Authority	Phone Number	Date

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