MICHIGAN Department of Education

# Medical Statement for Student *Without* a Disability

Requesting Special Foods in Child Nutrition Programs

Student's Name: ______________________________ Age: __________ Grade: __________

Name of parent/guardian: _________________________ Phone Number: ________________

Description of child's medical or other special dietary needs that restrict the child's diet:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

| Foods to Omit: | Foods to Substitute: |
|---|---|
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

Other information regarding diet or feeding: (provide additional information below or on back of form or attach to this form).

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Signature of Medical Authority

Office Phone Number: _________________________ Date: __________________________

MDE/August 2001
Reviewed 8/2007