Child Nutrition Medical Statement for Meal Modifications

Contact Information – to be completed by the school

Student's Name	
Age / Grade	
School Name	
School Address	
School District	
School Principal	
Phone	
Teacher	
Child Nutrition Manager	
Other Team Members	

Medical Statement – to be completed by a licensed physician or other healthcare professional with prescriptive authority in Arkansas

Patient's Name	
Dietary Restriction(s) *A brief explanation of the physical or mental impairment and how it affects the diet*	
Accommodation(s) Needed *May include, but is not limited to, food(s) to avoid or restrict, food(s) to substitute, caloric modifications, substitution of liquid nutritive formula, etc.*	

If additional information, including nutrition education materials shared with the family, is available and/or necessary, please attach to this form or send to the school's Child Nutrition Manager.

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Date Signature of Licensed Physician