Date_____

Will the student be eating meals prepared by the school? _____

Child Nutrition Medical Statement for Meal Modifications

Contact Information – to be completed by the school

Student's Name	
Age / Grade	
School Name	eStem Junior High Downtown
School Address	123 W 3rd Street Little Rock, AR 72201
School District	eStem Public Charter Schools
School Director	Melissa Gray
Phone	501-748-9342
School Nurse	Natalee Miller, RN
Child Nutrition Manager	Stacy Awbrey
Other Team Members	Preferred Meals

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.

_____ _____

Date Signature of Licensed Physician

Updated: CNU 2017
Updated: eStem 9/2018