Child Nutrition Medical Statement for Meal Modifications

Graduate Arkansas Child Nutrition Department
6724 Interstate 30, Little Rock, AR 72209
501-500-9270
Shelia.bailey@graduatearkansas.org

PART ONE – To be completed by the school or parent

Student's Name	
Age	
Student ID Number	
Parent's Name/s (If applicable)	
Daytime Phone	
Today's Date	
School Name	
Print Physician's Name	
Office Phone Number	

PART TWO – To be completed by a licensed physician or other healthcare professional with prescriptive authority in Arkansas

Dietary Restriction(s) A brief explanation of the physical or mental impairment and how it affects the diet	
Accommodation(s) Needed (foods to be avoided) 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.	
Substitution(s)	

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 Director.

Date_____ Signature of Licensed Physician_____

Revised 8/26/2020