Child Nutrition Unit Arkansas Department of Education

**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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