**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