School:_____

Student Name:_____ Student ID #:_____ Date:_____

School Nurse:_____

Medical Statement
Participants without Disabilities

Part I To be completed by Sponsor or Parent/Guardian

Name of Participant: _____

Part II To be completed by a State licensed health care professional who is authorized to write medical prescriptions under State law* or a Registered Nurse (RN) or a Registered Dietitian (RD).

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the patient's diet)

_____

_____

_____

_____

List foods to be omitted from diet:

_____

_____

_____

_____

_____

List foods to be substituted:

_____

_____

_____

_____

_____

_____

Signature of Licensed Health Care Professional or Registered Dietitian:

_____ Date_____

*Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD)

This institution is an equal opportunity provider.