Medical Statement For Participants With Allergies/Chronic Diseases
Enterprise Elementary School District

Parents or medical personnel may complete this form (dietician, speech pathologist, and occupational therapist), but a physician or other recognized medical authority must sign in agreement as to what is written. For the purposes of this program, a "recognized medical authority" means a licensed physician, nurse, or physician's assistant.

School Site Name	Phone
Site Contact Person	Fax

Student's Name	Birth Date	
Student's Age	Grade Level	Teacher
Parent/Guardian Name	Telephone	Address

1. Does the student have a disability? If yes, describe the major life activities affected by the disability.	◯ Yes ◯ No
If Yes, does the student have special nutritional or feeding needs? If Yes, complete this form and have it signed by a physician.	◯ Yes ◯ No
If the student is not disabled, does he/she have special nutritional or feeding needs? If Yes, complete this form and have it signed by the appropriate medical authority.	◯ Yes ◯ No
List or attach any dietary restriction, special diet, food intolerance, and/or allergies.	
List or attach any substitution foods recommended.	
List any special equipment or utensils needed.	
Indicate any other comments regarding the student's eating or feeding patterns and requirements.	
We will fax or mail school meal menus to the appropriate medical authority for modification if necessary. Please call the school STUDENT SERVICES CLERK or HEALTH CLERK to request this service.	
Parent Signature	Date
Physician/Medical Authority Signature	Date
Physician Name (please print)	Phys. Office Phone Number

COPIES TO: ___Nurse's Office ___ACE Office ___School File ___Transportation ___Nutrition Office ___Kitchen