LEE COUNTY SCHOOLS

Child Nutrition Department

Mr. Coke Magee, Superintendent

Medical Statement for Dietary Modification for DISABLED Child

*(Medical statement must be **RENEWED ANNUALLY** by a medical authority and can only be changed by a medical authority.)*

Part I: *To be filled out by School District/School/Organization/Sponsor*

Date:_____

Name of Student:_____

Address:_____

Date of Birth:_____

Name of School District: LEE COUNTY SCHOOLS

School/Provider/Center Name:_____

School/Provider/Center Address:_____

Part II: *To be filled out by a Physician*

Name of Patient: _____Age: _____

Diagnosis: _____

_____

Describe the individual's disability and the major life activity affected by the disability:_____

_____

_____

Does the disability restrict the individual's diet? Yes_____ No_____

If yes, list the food(s) to be omitted from the student's diet **AND** food(s) that may be substituted:_____

_____

If applicable, list any special equipment:_____

_____ _____

Signature of Physician **Date**