LEE COUNTY SCHOOLS

Child Nutrition Department

Mr. Coke Magee, Superintendent

Medical Statement for Dietary Modification for NON - 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 Medical Authority*

Name of Patient: ____Age: __________

Diagnosis: ____

____

Describe the medical or other special dietary needs that restrict the child's diet:________________________

____

List the foods to be omitted from the student's diet:______________________________________

____

List the foods that may be used in substitution of the omitted foods:_________________________

____

If applicable, list any special equipment:____

____ ____________________

Signature of Medical Authority **Date**

Updated: 1/10/2020

This institution is an equal opportunity provider.