STUDENT NAME:		STUDENT ID#:	

PART B *(To be completed by a **RECOGNIZED MEDICAL AUTHORITY**, i.e., Licensed physicians, physician assistants, and nurse practitioners)*

Describe the student's physical or mental impairment:	**Explain how the impairment restricts the student's diet:**

Major life activities affected: *Select all that apply.*

☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Performing manual tasks ☐ Adaptive Equipment *(please specify):*

☐ Learning ☐ Breathing ☐ Self-Care ☐ Eating/Digestion

Is this a Food Allergy? ☐ YES ☐ NO

Is this a Food Intolerance? ☐ YES ☐ NO

If student has life threatening allergies* check appropriate box(es):

**Students with life threatening food allergies must have an emergency action plan in place at school.*

☐ Ingestion ☐ Contact ☐ Inhalation

Specify any dietary restrictions or special diet instructions for accommodating this student in school meals:

For *any* special diet, list specific foods to be omitted and the recommended substitutions. *(You may attach a separate care plan)*

Foods to be Omitted →	Recommended Substitutions	Foods to be Omitted →	Recommended Substitutions

Designate safest consistency requirement for FOOD:

☐ Pureed ☐ Mechanical Soft ☐ Other *(please specify):*

☐ Ground ☐ Chopped

Designate safest consistency requirement for LIQUIDS:

☐ Clear Liquid ☐ Nectar-thick ☐ Other *(please specify):*

☐ Full Liquid ☐ Honey-thick

☐ Pudding-thick

Other comments about the child's eating or feeding patterns, including tube feeding if applicable:

NOTE* If your assessment of the child does not yield sufficient data to fully complete the above sections applicable to the student's mealtime needs, please refer the child/family to the appropriate health care professional for completion of the assessment.

Signature of Recognized Medical Authority*	Printed Name	Phone Number	Date
		( )	

** A recognized medical authority in HI includes licensed physicians, physician assistants, naturopathic physician, nurse practitioners, or osteopathic physician.*

PART C *To be completed by **CNP ADMINISTRATORS NSLP, CACFP, SFSP, FFVP)***

SFA/SPONSOR Administrator's Signature: **Date:**

IEP/504 Coordinator Signature: **Date:**

NOTES: *(School Nutrition, School Program, CACFP or SFSP Administrator only)*

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's school, CACFP or SFSP provider.

Received on: _____

Processed date: _____