## **Child Nutrition Medical Statement for Meal Modifications**

**Contact Information** – to be completed by the school

Student's Name	
Age / Grade	
School Name	
School Address	
School District	
School Principal	
Phone	
Teacher	
Child Nutrition Manager	
Other Team Members	
<b>Medical Statement</b> – to be completed by a licensed physician or other healthcare professional with prescriptive authority in Arkansas	
Patient's Name	
Dietary Restriction(s)	
A brief explanation of the physical or mental impairment and how it affects the diet	
Accommodation(s) Needed	
May include, but is not limited to, food(s) to avoid or restrict, food(s) to substitute, caloric modifications, substitution of liquid nutritive formula, etc.	
If additional information, including nutrition education materials shared with the family, is available and/or necessary, please attach to this form or send to the school's Child Nutrition Manager.	
Date	Signature of Licensed Physician