

**Child Nutrition Medical Statement for Meal Modifications****Contact Information** – to be completed by the school

<b>Student's Name</b>	
<b>Age / Grade</b>	
<b>School Name</b>	
<b>School Address</b>	
<b>School District</b>	
<b>School Principal</b>	
<b>Phone</b>	
<b>Teacher</b>	
<b>Child Nutrition Manager</b>	
<b>Other Team Members</b>	

**Medical Statement** – to be completed by a licensed physician or other healthcare professional with prescriptive authority in Arkansas

<b>Patient's Name</b>	
<b>Dietary Restriction(s)</b>  <i>A brief explanation of the physical or mental impairment and how it affects the diet</i>	
<b>Accommodation(s) Needed</b>  <i>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.</i>	

*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