

**Medical Statement
Participants with Disabilities**

Part I To be completed by Sponsor or Parent/Guardian

Name of Participant: _____

Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law.*

<p>Diagnosis (include description of the patient's disability and the major life activity or major bodily function affected by the disability):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Does the disability restrict the patient's diet? Yes _____ No _____</p> <p>If yes, list how disability restricts diet:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>Diet Plan:</p> <p>Foods to be omitted from diet:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Foods to be substituted (include modifications of texture or consistency that may be necessary):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Signature of Licensed Health Care Professional: _____</p> <p style="text-align: right;">Date _____</p>

*Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD)