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.*

Diagnosis (include description of the patient's disability and the major life activity or major bodily function affected by the disability):

_____

_____

_____

Does the disability restrict the patient's diet? Yes _____ No _____
If yes, list how disability restricts diet:

_____

_____

_____

_____

Diet Plan:

Foods to be omitted from diet:

_____

_____

_____

_____

Foods to be substituted (include modifications of texture or consistency that may be necessary):

_____

_____

_____

_____

_____

Signature of Licensed Health Care Professional:

_____ Date_____

*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)