

MEDICAL STATEMENT FOR PARTICIPANTS WITH ALLERGIES/CHRONIC DISEASES

Other medical personnel may complete this form (dietitian, speech pathologist, occupational therapist), but a physician or other recognized medical authority must sign in agreement as to what is written. For the purposes of this program, a "recognized medical authority" means a licensed physician, nurse or physician's assistant.

Participant	Age	Agency	
Parent Name	Telephone ()	Site	Telephone ()

Food Allergy/Chronic Disease:

Diet Prescription And/Or Texture Modification: *(Please describe in detail to ensure proper implementation and compliance.)*

Indicate texture: Regular Chopped Ground Pureed

Foods To Be Omitted And Substitutions: *(Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.)*

Foods To Be Omitted

Suggested Substitutions

Signature of Preparer 	Printed Name	Telephone ()	Date
Signature of Recognized Medical Authority 	Printed Name	Telephone ()	Date