



Medical Statement

A state licensed healthcare professional who is authorized to write medical prescriptions under state law must complete Parts 2 and 3 and sign this form. In Florida, this includes a Physician, Physician's Assistant or Nurse Practitioner (ARNP). The parent or guardian must complete Part 1.

PART 1: GENERAL INFORMATION - Completed by the parent/guardian

First and Last Name	Date of Birth
Name of Center/Care Provider	
Name of Parent/Guardian	Telephone Number

PART 2: ACCOMODATIONS - Completed by a licensed medical professional

How does the participant's physical or mental impairment restrict their diet?

What food(s)/type(s) of food must be omitted? Please be specific.

List food(s) to be substituted for omitted food(s). (Avoid specific brand names, if possible)

Additional comments:

Texture modification (Complete if needed):

<input type="checkbox"/> Pureed	<input type="checkbox"/> Ground	<input type="checkbox"/> Bite-Size Pieces	<input type="checkbox"/> Other (specify)
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PART 3: SIGNATURE - Completed by a licensed medical professional

Licensed medical professional's name	Title: <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner (ARNP) <input type="checkbox"/> Physician Assistant
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Signature of licensed medical professional	Date signed
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Medical office name and address	Phone number
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