

Indian Creek Schools
Medical Statement for Students Requiring
Special Meals and/or Accommodations

Please note: This form must be updated whenever there is change or discontinuance of a diet order.

Student's Name: _____

Birthdate: _____

School Attending: _____

Grade: _____

Parent/Guardian Name: _____

Best phone number to reach parent/guardian: _____

I hereby give permission for the school staff to follow the stated nutrition plan outlined below. I give my permission for the School Nutrition Services to contact the physician named below with any questions related to my child's nutrition requirements and to share such information with appropriate school personnel.

Signature Parent/Guardian

Date

*******FOR PHYSICIAN'S USE ONLY******* (To be completed by a licensed physician)

Identify Student's Disability or Medical Condition (including allergies) requiring the student to need a special diet/diet accommodations:

Food Allergy (list all:)

Substitutions needed:

Physician Name: _____ **Phone:** _____

_____ **Date:** _____



4/2017