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):

☐ Pureed	☐ Ground	☐ Bite-Size Pieces	☐ Other (specify)

PART 3: SIGNATURE - Completed by a licensed medical professional

Licensed medical professional's name	Title: ☐ Physician ☐ Nurse Practitioner (ARNP) ☐ Physician Assistant
Signature of licensed medical professional	Date signed
Medical office name and address	Phone number