Diet/ Medical Statement for Children with Special Dietary Needs

Child's Name:___________________________________ Child's date of Birth:___________________

Child Care Provider/Facility Name:____

Does the child have a disability? Yes ☐ No ☐

> ***What is a Disability?*** **Physical or mental impairment that substantially limits one or more major life activities (includes eating, breathing, digestive and respiratory functions, etc.). Most physical and mental impairments will constitute a disability, it does not need to be life threatening. Ex. Digestion is impaired by lactose intolerance, whether or not consuming milk causes severe distress.**

Describe impairment and the major life activities affected by the disability.

List how to accommodate the impairment/ dietary restrictions:

List recommended foods to be substituted:

Indicate any other comments about the child's eating and feeding patterns:

Physician, Physician Assistant, or Nurse Practioner (APNP)

Signature:____Date:____________________________________

Parent/Guardian

Signature:____Date:____________________________________