CALIFORNIA DEPARTMENT OF EDUCATION
CHILD NUTRITION AND FOOD DISTRIBUTION DIVISION
CNFDO -MSA (03/95)

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.

Name of Participant	Age
Patient Name	Telephone ( )

Agency	
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