

# CHILD NUTRITION PROGRAM

“Improved student performance with good nutrition”

## MEDICAL STATEMENT FOR SPECIAL DIET

### Part I

Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Name of School District: Houston School District

School Attended by Student: \_\_\_\_\_

### Part II (To be filled out by a Medical Authority)

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

List food(s) to be omitted from diet and food(s) that may be substituted:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Special Equipment needed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Medical Authority

Houston School District  
P.O. Drawer 351  
636 Starkville Road  
Houston, MS 38851

PHONE (662) 456-5688  
FAX (662) 456-5259  
E-MAIL [mmarsh@houston.k12.ms.us](mailto:mmarsh@houston.k12.ms.us)  
WEB SITE <http://www.houston.k12.ms.us>