MANSFIELD PUBLIC SCHOOLS
HEALTH SERVICES

MEDICAL STATEMENT For Children Requiring Special Foods in School Nutrition Program

After completion, the form should be sent to the School Nurse and will be forwarded to the Food Services Deptarment.

Part I (to be filled out by School District or Parent/Guardian)

Name of Student_________________________________ D.O.B.__________________

Name of Parent/Guardian_________________ Telephone Number__________________

School District________________ School Attended by Student_____________________

Part II (to be filled out by a Physician)

Diagnosis (Include description of the patient's medical or other dietary needs that restrict the child's diet):

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List food(s) to be omitted from diet:

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Additional Information:

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___________ ________________________________
Date Signature of Physician

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Physician's Telephone Number