Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Office of Student Services
Child Nutrition Programs
(503) 947-5894

Organization Name
Medical Statement - for Accommodating Disabilities

Submit this form to: _____

Site/Provider Name: _____

Part I To be completed by Parent/Guardian or Sponsor

Name of Participant: _____

Parent/Guardian Name _____Phone #_____

Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law*. Answer questions 1-3.

1. Describe the major life activity or major bodily function affected by the participant's physical or mental impairment that restricts the diet:

_____

_____

_____

2. Meal Accommodation Plan (Foods to omit or avoid):

_____

_____

_____

3. Foods to be substituted and recommended alternatives (include modification and accommodation)

_____

_____

_____

_____

Signature of Licensed Health Care Professional*:

_____ Date_____

Sponsor's use: Accommodation made:

_____

Staff Signature_____ Date_____

*Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD)