Medical Statement/Diet Prescription for
Children with Disabilities Requiring Special Nutrition Services
Anniston City School Nutrition Program

Part I (to be completed by Parent or Guardian)

Last Name ______________________ First Name ______________________ MI ____

SSN ____________ Date of Birth ______________ Age ______

School Name ____________________

Name of parent /guardian ________________________________ Daytime Phone # ____________

Part II (to be completed by Physician)

Patient's Diagnosis Description: *If a special diet is required you must attach a detailed diet plan with this prescription*

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:

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Texture Modification

Indicate which dietary modification the patient needs.

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Tube Feeding Required ☐ YES ☐ NO Formula Name if required ____________________________

Nutrient Modification

Increase Calories ☐ YES ☐ NO List supplement if required ____________________________

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Decrease Calories ☐ YES ☐ NO

Descriptiom ____

Nutrient Restriction

Descriptiom ____

Special Equipment ____

Dietitian's Name if Required ______________________ Phone Number ____________

Physician's name ______________________ Phone Number ____________

Physician's Signature ____