

BAKERSFIELD CITY SCHOOL DISTRICT
Health Services Department
714 Williams Street
Bakersfield, California 93305

MEDICAL STATEMENT
For
PARTICIPANTS WITH DISABILITIES REQUIRING SPECIAL MEALS

Other medical personnel may complete this form (dietitian, speech pathologist, occupational therapist), but a physician must sign in agreement as to what is written.

Name of Participant	Age	Agency	
Parent Name	Telephone	Site	Telephone

Disability or medical Condition Requiring a Special Diet: _____

Brief Description of Participant's Major Life Activity Affected by Disability: _____

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

Special Feeding Equipment _____

Signature of Preparer	Printed Name	() Telephone	Date
Signature of Physician	Printed Name	() Telephone	Date