

**Exhibit 6.1. Medical Statement for Disabled Child**

**Mississippi Department of Education  
Office of Child Nutrition  
Medical Statement for Disabled Child**

**Part I (to be completed by School District/School/Organization/Sponsor)**  
Date \_\_\_\_\_  
Name of School District/School/Organization/Sponsor \_\_\_\_\_  
Name of Student/Disabled Person \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_ Date of Birth \_\_\_\_\_  
School/Provider/Center Name \_\_\_\_\_  
School/Provider/Center Address \_\_\_\_\_

**Part II (to be completed by the Physician)**  
Patient's Name \_\_\_\_\_ Age \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
\_\_\_\_\_  
Describe the individual's disability and the major life activity affected by the disability \_\_\_\_\_  
\_\_\_\_\_  
Does the disability restrict the individual's diet? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, list food(s) to be omitted from diet and food(s) that may be substituted \_\_\_\_\_  
\_\_\_\_\_  
Special equipment needed \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Physician \_\_\_\_\_