Exhibit 6.1. Medical Statement for a Disabled Child

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

PART I (to be completed by school district/organization/sponsor)

Date: ________________________

Name of School District/School/Organization/Sponsor ____

Name of Student/Individual ____

Address ____

Date of Birth _________________________

School/Provider/Center Name ____

School/Provider/Center Address ____

PART II (to be completed by a physician)

Patients Name____ Age ______________

Diagnosis ____

Describe the individual's disability and the major life activity affected by the disablility

Does the disability restrict the individual's diet? Yes No

If yes, list the food(s) to be omitted from the child's diet and food(s) that may be substituted

Special equipment needed

Date ___________________ Signature of Physician ____