Exhibit 6.1. Medical Statement for a Non-Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for a Non-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 medical authority)

Patients Name____ Age ______________

Diagnosis ____

Describe the medical or other special dietary needs that restricts the child's diet

List the food(s) that should be omitted from the child's diet and food(s) that may be substituted based on the answer given above

Special equipment needed

Date ________________________

Signature of Medical Authority ____