MEDICAL/RELIGIOUS PRACTICE STATEMENT
FOR STUDENTS WITH DISABILITIES
OR SPECIAL DIETARY NEEDS

Part I (to be filled out by the school)

Name of Student_______________________________ Date________________
School_____________________________________ Room Number ___________

Part II (to be filled out by a medical physician/religious authority)

(Requests for religious reasons must attach a written request on official letterhead
from the pastoral head—e.g., priest, rabbi, or imam—of the religious organization.)

Patient’s Name___________________________________ Age_______________
Diagnosis
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Describe the medical or other special dietary needs that restrict the child’s diet
(if diabetic, the enclosed meal pattern must be completed):
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

List food(s) to be omitted from the diet and food(s) that may be substituted (diet
plan):
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Special equipment:
__________________________________________________________________
__________________________________________________________________

______________________________________________________________
Signature of Medical Physical/Religious Authority                       Date

Revised July 14, 2006
Attachment C