MEDICAL STATEMENT
FOR
PARTICIPANTS WITH ALLERGIES/CHRONIC DISEASES

Other medical personnel may complete this form (dietitian, speech pathologist, occupational therapist), but a physician or other recognized medical authority must sign in agreement as to what is written. For purposes of this program, a "recognized medical authority" means a Naturopathic or Osteopathic physician, Registered Nurse, Registered Dietician, Nurse Practitioner or other professionals specified by the State agency.

Name of Participant	Age	School	Grade
Parent Name	Telephone	Additional information	

Food Allergy/Chronic Disease:

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

Signature of Preparer/Title	Printed Name	Telephone	Date
Signature of Recognized Medical Authority/Title	Printed Name	Telephone	Date