Medical Statement

A State Licensed Healthcare Professional (in WI these are Physician, Physician Assistant, or Nurse Practitioner (APNP)) must complete Parts 2, 3, and 4 and sign this form.

PART 1: PARTICIPANT INFORMATION	
Participant's First and Last Name	Date of Birth
Name of Agency/Care Provider	
Name of Parent/Guardian	Telephone Number

PART 2: PURPOSE FOR REQUEST
Participant has a *physical or mental impairment that limits one or more major life activities (includes eating, breathing, digestive and respiratory functions, etc.)* and requires a special meal or accommodation**.** The impairment(s) or reason(s) for request (e.g. food allergy/ intolerance, etc.):

PART 3: COMPLETE ALL SECTIONS BELOW THAT ARE APPLICABLE			
3A: How to accommodate the impairment(s) (or attach specific diet order instructions):			
3B: Food(s) to be Omitted		3B: Food(s) to be Substituted	
3C: Texture Modification (Complete if needed)			
☐ Pureed	☐ Ground	☐ Bite-Size Pieces	☐ Other (specify):

PART 4: SIGNATURES	
Signature of Physician, Physician Assistant, or Nurse Practitioner (APNP)	Date:
Printed Name of Physician, Physician Assistant, or Nurse Practitioner (APNP)	Phone Number:
Medical Office Name and Address:	