Exhibit 6.1. Medical Statement for Disabled Child

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

Part I (to be completed by School District/School/Organization/Sponsor)
Date_____

Name of School District/School/Organization/Sponsor_____

Name of Student/Disabled Person_____

Address_____

_____Date of Birth_____

School/Provider/Center Name_____

School/Provider/Center Address_____

Part II (to be completed by the Physician)

Patient's Name_____Age_____

Diagnosis_____

_____

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

_____

_____

Does the disability restrict the individual's diet? Yes_____ No_____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted_____

_____

_____

Special equipment needed_____

_____

_____

_____ _____
Date Signature of Physician