



El Paso Independent School District
Food and Nutrition Services Department
Medical Statement
Requesting Special Food in Child Nutrition Programs
FAX TO: (915) 771-1112

Child's Name: _____ DOB: _____

Address: _____ Telephone: _____

School: _____

Diagnosis: (Include description of the patient's medical or other special dietary needs that restrict the child's diet)

List food(s) to be omitted from diet: _____

List food(s) that may be substituted (Diet Plan): _____

Length of time diet will be required: _____

Additional Information: _____

I do hereby give my consent for the release and exchange of information contained in the medical or professional record of my child.

Parent/Guardian Signature

Date

MD Name (Printed)

Physician's Signature

MD Phone # / MD Fax #

Date