## Child Nutrition Medical Statement for Meal Modifications

**Little Rock School District Child Nutrition Department**
**1501 Jones Street, Little Rock, AR 72202 (501)447-2450**
**childnutrition@lrsd.org**

**PART ONE –** To be completed by the school or parent

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|---|---|
| **Student's Name** | |
| **Age / Grade** | |
| **Student ID Number** | |
| **Parent's Name(s)** | |
| **Daytime Phone** | |
| **Today's Date** | |
| **School Name** | |
| **Print Physician's Name** | |
| **Office Phone Number** | |

**PART TWO –** To be completed by a licensed physician or other healthcare professional with prescriptive authority in Arkansas

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|---|---|
| **Dietary Restriction(s)**<br><br>*A brief explanation of the physical or mental impairment and how it affects the diet* | |
| **Accommodation(s) Needed (foods to be avoided)**<br><br>*May include, but is not limited to, food(s) to avoid or restrict, food(s) to substitute, caloric modifications, substitution of liquid nutritive formula, etc.* | |
| **Substitution(s)** | |

*If additional information, including nutrition education materials shared with the family, is available and/or necessary, please attach to this form or send to the school's Child Nutrition Manager.*

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Date Signature of Licensed Physician

**Revised April 2018**