Medical Statement
Participants with Disabilities

Parte I Para ser completada por el patrocinador o el padre/tutor
Part I To be completed by Sponsor or Parent/Guardian

Nombre del participante: ____

Parte II Debe ser completado sólo por un médico con licencia: Doctor médico (MD) o Doctor de Osteopatía (DO)
Part II To be completed only by a Licensed Physician: Medical Doctor (MD) or Doctor of Osteopathy (DO)

Diagnosis (include description of the patient's disability and the major life activity or major bodily function affected by the disability):

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Does the disability restrict the patient's diet? Yes _____ No _____
If yes, list how disability restricts diet:

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Diet Plan:

Foods to be omitted from diet:

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Foods to be substituted (include modifications of texture or consistency that may be necessary):

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Date:_____________ Signature of Licensed Physician: ______________________________

USDA y esta institución son proveedores y empleadores que ofrecen oportunidad igual a todos.