Medical Statement
Participants with Disabilities

Part I To be completed by Sponsor or Parent/Guardian

Name of Participant: _____

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):

_____

_____

_____

_____

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

_____

_____

_____

_____

Diet Plan:

Foods to be omitted from diet:

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Date:_____ Signature of Licensed Physician: _____

USDA and this institution are equal opportunity providers and employers.