Medical Statement
Participants without Disabilities

Part I To be completed by Sponsor or Parent/Guardian

Name of Participant: ____

Part II To be completed by one of the following medical authorities: Medical Doctors (MD), Doctor of Osteopathy (DO), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practitioners (NP), Registered Nurses (RN), Naturopathic Physician (ND), and Naturopathic Doctor of Osteopathy (NDO)

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

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List foods to be omitted from diet:

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List foods to be substituted:

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Date ________________ Signature of Medical Authority__________________________________

USDA and this institution are equal opportunity providers and employers.