
Exhibit 6.1. Medical Statement for Disabled Child

**Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Disabled Child**

Part I (to be completed by School District/School/Organization/Sponsor)

Date_____

Name of School District/School/Organization/Sponsor_____

Name of Student/Disabled Person_____

Address_____

_____ Date of Birth_____

School/Provider/Center Name_____

School/Provider/Center Address_____

Part II (to be completed by the Physician)

Patient's Name_____ Age_____

Diagnosis_____

Describe the individual's disability and the major life activity affected by the disability_____

Does the disability restrict the individual's diet? Yes_____ No_____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted_____

Special equipment needed_____

_____ Date

_____ Signature of Physician
