Early Head Start
UTRGV

UTRGV - PSJA - EHS - CC
Partnership Program

MEDICAL STATEMENT
TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. Center Name:	2. Center Phone Number:
3. Name of Child/Infant:	4. Date of Birth:

5. PART A:

Does the child/infant have a disability:

□NO- Go to Part B

□YES- Describe child's/infant's disability:_____

Describe major life activity or activities affected by the disability: _____

Describe food accommodation and complete Part C: _____

PART B:

Child has no disability but requires a special diet:

□ NO- STOP HERE

□YES- Describe special dietary need that restricts diet and complete Part C:_____

6. PART C:

List specific foods to be omitted and suggested substitutions
(You may attach a sheet with additional information as needed)

Foods To Be Omitted	Suggested Substitution
_____	_____
_____	_____
_____	_____

7 Indicate Texture:

□ Regular □ Chopped □ Ground □ Pureed

8. Describe Adaptive Equipment if needed:_____

9. Signature of Medical Authority:_____

10. Printed Name:_____

11. Telephone Number:_____ **12. Date:**_____

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