



Gulfport School District Annual Medical Statement for Students with Special Nutritional Needs

Part 1 (to be filled out by parent or guardian) (Must be completed yearly)

Student ID# _____

Name of Student (Last) _____ (First) _____ MI _____

Social Security Number _____ Date of Birth _____ Age _____

School Attended by Student _____ **Grade** _____ **School Year** _____

What meals will student eat at School? Breakfast ___ Lunch ___ After School Program ___ (please check appropriate meals)

Name of Parent/Guardian(s) _____ *Signature* _____

Parent/Guardian Phone Numbers _____ home _____ work _____ cell _____

Mailing Address _____ City _____ Zip _____

Part 2 (to be filled out by a Licensed Physician)

Student Diagnosis _____

R

E

Q

U

I

R

E

D

MD Please indicate specific Patient needs:

Food allergies: list specific foods and severity:

Ingestion _____ Contact _____ Inhalation _____
(very important)

Nutrient Modification: (cholesterol, sodium, gluten) etc.

Diabetic (please provide diet instruction materials) and Grams of CHO for

Breakfast _____ lunch _____

Total Daily Calories _____

Lactose Intolerance : no milk to drink _____
Avoid all dairy products _____

Texture Modification: _____ pureed _____ ground
_____ chopped _____ other

Note: All Special Diets must include a specific diet instruction!

Physician (please print) _____ Phone () _____

Physician Signature _____ Date: _____

Part 3: R.N.'s Signature _____ Date _____
(School Nurse)

R.D.'s Signature _____ Date _____
(Child Nutrition Director's Signature)

Please Note: Students with Diabetes: Parents may request a menu be sent home for them to select food for elementary students or may go on line to the Child Nutrition web page and download menus. Please send selected menu items directly to the school.

Information provided on this form will be used by Child Nutrition to prepare and serve the student's special diet. It will not be released except to those responsible for the student's meals or the school nurse.