Waynesfield-Goshen Local SD **Special Dietary Medical Needs Form**

Must be completed by a licensed physician or a licensed medical authority to receive accommodations.

Student Name_____	Grade_____
PART A	
Diagnosed Disability for dietary modification: _____ Does this disability require special nutritional or feeding needs? If yes, complete Part B of this form and have it signed by a licensed physician or licensed medical authority.	
PART B	
List specific food group/beverage affected by disability:	
List preferred food group/ beverage to be used for substitution:	
Other Diet Modifications or Special Instructions:	
Licensed Physician or Medical Authority: Name_____ Telephone_____ Fax_____ Physician Signature_____ *(required*)	
Parent/Legal Guardian Name (Print)_____ Parent/Legal Guardian Signature_____ Preferred Contact Phone Number_____	
For office use only School Authority Title_____ Signature_____ Date_____	