

**Medical Statement
Participants without Disabilities**

Part I To be completed by Sponsor or Parent/Guardian

Name of Participant: _____

Part II To be completed by a State licensed health care professional who is authorized to write medical prescriptions under State law* or a Registered Dietitian (RD).

<p>Diagnosis (include description of the patient's medical or other special dietary needs that restrict the patient's diet)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List foods to be omitted from diet:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List foods to be substituted:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Signature of Licensed Health Care Professional or Registered Dietitian:</p> <p style="text-align: right;">_____ Date _____</p>
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*Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD)