Medical Statement
Participants with Disabilities

第 1 部分：由贊助人或家長/監護人填寫
Part I To be completed by Sponsor or Parent/Guardian

參加者姓名：_____

第二部分 僅限州法*授權開立醫療處方箋且持有州執照的醫療保健專業人士填寫*
Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law*

Diagnosis (include description of the patient's disability and the major life activity or major bodily function affected by the disability):

_____

_____

_____

Does the disability restrict the patient's diet? Yes _____ No _____
If yes, list how disability restricts diet:

_____

_____

_____

Diet Plan:

Foods to be omitted from diet:

_____

_____

_____

Foods to be substituted (include modifications of texture or consistency that may be necessary):

_____

_____

_____

Date:_____ Signature of Licensed Physician: _____

*醫學醫師（MD）；骨科醫師（DO）；自然療法醫師（ND）；醫師助理（PA）；合格專科護理師或臨床專科護理師；牙科醫師（DMD）；牙外科醫師（DDS）；驗光醫師（OD)

*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)

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