

**Medical Statement
Participants without Disabilities**

第 1 部分：保荐人或家长/监护人可完成

Part I To be completed by Sponsor or Parent/Guardian

參加者姓名： _____

到第二部分由国家持牌医疗保健专业人员有权写下国家法律 * 或注册护士 (RN) 或注册营养师 (RD) 医疗处方完成。

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 Nurse (RN) or a Registered Dietitian (RD).

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the patient's diet)

List foods to be omitted from diet:

List foods to be substituted:

Date _____ Signature of Medical Authority _____

*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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