Medical Statement
Participants with Disabilities

Parte I Para ser completada por el patrocinador o el padre/tutor
Part I To be completed by Sponsor or Parent/Guardian

Nombre del participante: _____

Parte II Para *completarla solamente* por un profesional sanitario licenciado por el Estado, autorizado para recetar prescripciones médicas bajo la ley estatal*
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: _____

*Doctores de medicina (MD); Doctores de Osteopatía (DO); Doctores de Naturopatía (ND); Asistentes médicos (PA); Enfermera certificada o especialista clínico; Doctor de medicina dental (DMD); Doctor de cirugía dental (DDS); Doctor de Optometría (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)

Esta institución es un proveedor que ofrece igualdad de oportunidades.