School:_____

Student Name:_____ Student ID #:_____ Date:_____

School Nurse:_____

Medical Statement
Participants without Disabilities

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

Nombre del participante: _____

Parte II Para completarla por un profesional sanitario licenciado por el Estado, autorizado para recetar prescripciones médicas bajo la ley estatal* o una enfermera registrada (RN) o un dietista registrado (RD).
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_____

*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.