## Medical Statement
## Participants without Disabilities

**Part I** To be completed by Sponsor or Parent/Guardian

Name of Participant: _____

**Part II** To be completed by one of the following medical authorities: Medical Doctors (MD), Doctor of Osteopathy (DO), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practitioners (NP), Registered Nurses (RN), Naturopathic Physician (ND), and Naturopathic Doctor of Osteopathy (NDO)

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_____

USDA and this institution are equal opportunity providers and employers.