PROVIDER/CENTER NAME: ASSOC STUDENTS CSU LONG BEACH CHILD DEVELOP CTR
ISABEL PATTERSON CHILD DEVELOPMENT CENTER (562) 985-5333

REVISED
3/2021

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS OR ACCOMMODATIONS

The information on this form should be updated to reflect the current medical or nutritional needs of the participant.

PARENT COMPLETE THIS SECTION	
Child Name:	Birthdate:
Parent/Legal Guardian Name:	Phone Number:
Parent/Legal Guardian Signature: (permission to release medical information)	Date:

DOCTOR COMPLETE THIS SECTION		
Medical condition requiring a special diet/accommodation:		
Foods To Omit:	Approved Food Substitutions:	
List food and information regarding any need texture changes (chopped, ground, pureed, etc.) ☐ No Changes		
Adaptive equipment to be used: ☐ None		
*Healthcare Professional's Printed Name:	*Healthcare Professional's Signature:	Date:
Address:	Phone Number:	

*For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.

This institution is an equal opportunity provider.

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