

**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.