Scappoose School District

Medical Statement - for Accommodating Disabilities

Submit this form to: Michelle Brasmer

Site/Provider Name: Scappoose District Office

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

Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part II** To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law\*. Answer questions 1-3.

**1. Describe** the major life activity or major bodily function affected by the participant’s physical or mental impairment that restricts the diet:

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**2. Meal Accommodation Plan (Foods to omit or avoid):**

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**3. Foods to be substituted and recommended alternatives (include modification and accommodation)**

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Signature of Licensed Health Care Professional\*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsor’s use: Accommodation made:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*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)

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