CERTIFICATION OF MEDICAL CONDITION

CHILD'S INFORMATION (TO BE COMPLETED BY PARENT/GUARDIAN)

Child's Name:_____ Child's DOB:_____
Parent/Legal Guardian Name: _____
Parent/Legal Guardian Signature: _____

CHILD'S MEDICAL INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Note: MUST BE COMPLETED BY SLP, OT, DIETITIAN, OR PHYSICIAN. The parent/legal guardian listed above has applied for a service/equipment grant with the Pediatric Feeding Disorders Foundation. Please complete the following medical information.

Child's Primary Diagnosis: _____
Child's Secondary Diagnosis (if applicable): _____

How are the current diagnoses impacting the child's life? (check all that apply):

- O Medically
- O Socially
- O Psychologically/Behaviorally
- O Other: _____

I recommend the following (indicate and describe all that apply) and describe why they are needed:

- O Treatment: _____
  _____
- O Equipment: _____
  _____
- O Other: _____
  _____

Additional Notes/Concerns: _____
_____
_____

PROVIDER INFORMATION – ITEMS MARKED * ARE REQUIRED TO PROCESS FORM

*Medical Provider Name: _____ *Title: _____
Provider NPI #:_____ *Telephone: _____
Address: _____

*Signature: _____ Date: _____

Thank you for taking the time to complete this information. Please return this form back to the child's parent/legal guardian so that they may attach it to their child's grant application.