CERTIFICATION OF DISABILITY FOR SPECIAL DIETARY NEEDS

(PLEASE RETURN THE ORIGINAL FORM TO THE FOOD SERVICES DIRECTOR)

Forms will ONLY be accepted if filled out by a licensed physician!

PART 1 (To be completed by school or parent): Today's Date _____

School _____ School Phone Number _____

Student's Name _____ Grade _____ Age _____

Parent/Guardian's Name _____ Daytime Phone Number _____

MUST BE FILLED OUT COMPLETELY BEFORE SUBSTITUTIONS WILL BE MADE:

PART 2 (To be completed by a licensed physician ONLY) Please CHOOSE A or B

A. <u>FOR STUDENTS WITH A DISABILITY</u>

Describe the disability and check the major life activities affected by this disability.

_____

_____

_____ Caring for one's self _____ Seeing _____ Breathing

_____ Performing manual task _____ Hearing _____ Learning

_____ Walking Speaking Working

_____ Other (Describe) _____

B. <u>FOR STUDENTS WITHOUT A DISABILITY</u>

Identify the medical condition or other special dietary need that restricts the diet.

_____ Diabetes Mellitus _____ Reduced Calories _____ Increase Calories

_____ Modified Texture _____ Food Allergy (describe) _____

_____ Other (describe) _____

PART 3 To be completed by a licensed physician ONLY

Please list the food(s) to be omitted from the student's diet and the food(s) that may be substituted. <u>BE SPECIFIC.</u> **Substitutions will be made only if listed below.** Attach an additional sheet or use the back of this form if necessary.

Foods to be avoided	Substitution
_____	_____
_____	_____

_____

Signature of Physician Office Phone Number Today's Date

PART 4 Complete form to be reviewed and signed by the following:

_____ _____

Parent/Guardian Date School Principal Date

_____ _____

School Nurse Date Cafeteria Manager Date