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!

PARTE 1 (Completado por el médico, escuela o padre): Fecha de Hoy: _____

Escuela _____ Numero de telefono Escolar: _____

Nombre del Estudiante _____ Grado _____ Edad _____

Nombre del Padre/Custodio _____ Numero de Telefono de Dia _____

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:

_____		_____	
Pardre/ Custodio Legal	Fecha	Director Escolar	Fecha
_____		_____	
Enfermera Escolar	Fecha	Supervisor de la Cafetería	Fecha