

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. FOR STUDENTS WITH A DISABILITY

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

_____ caring for one's self _____ seeing _____ breathing
_____ performing manual tasks _____ hearing _____ learning
_____ walking _____ speaking _____ working
_____ other (Describe) _____

B. FOR STUDENTS WITHOUT A DISABILITY

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

_____ Diabetes _____ Reduced Calorie _____ Increased Calorie
_____ 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. **BE SPECIFIC. 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: Completed form to be reviewed and signed by the following:

Parent/Guardian Date School Principal Date

School Nurse Date Cafeteria Manager Date