4.50-School Meal

CERTIFICATION OF DISABILITY

For Special Dietary Needs

Part I (to be completed by the school)

Student's Name: ____ **Age:** ________

School Name and Address: ____

____

School District: ____

School Principal: ____**Phone:** _____________________________

Teacher: ______________________________________ **Food Service Manager:** ____________________________

Other Team Members: ____

Part II (to be completed by a licensed physician)

A student with a disability as defined by the Federal regulations for child nutrition programs is one who has a "physical, mental impairment which substantially limits one or more major life activities such as, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

Patient's Name: ____

Diagnosis: ____

____

____

Describe the patient's 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: ____

Does the disability restrict the individual's diet? ☐ Yes ☐ No

If yes, list the food(s) to be omitted, substituted, requiring texture changes, or caloric modification.

____

____

____

____

____________________________ ____________________________________

Date Signature

Part III (optional to be completed when appropriate by a licensed Registered Dietitian (RD),

Nurse (RN), or other health care team member).

Instructions given to parents regarding child's nutritional needs:

____

____

____

List the nutrition materials given to parents for school use:

____

____

____

____

Describe the special feeding device(s) needed:

____

____

____

Describe the feeding assistance needed:

____

____

____

Specify special dining area requirements:

____

____

____

Specify any special food preparation and storage needs:

(i.e., tube feeding blended in an approved food preparation area with attention paid to

maintaining the product below 45 and above 140 degrees.)

____

____

____

____

____

____

_____________________________ _____________________________

Signature of RD, RN, and/or Health Care Team Member

Facility of Agency

____

Phone Number

____

Date

____

Mailing Address

Relates to School Board Policy 4.50