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 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 Student Handbook pg. 122