**CERTIFICATION OF DISABILITY FOR SPECIAL DIETARY NEEDS**

Please take to MD and bring/fax back to Nurse. 870-741-3339

**Forms must be signed by a licensed physician**

**MUST BE FILLED OUT COMPLETELY BEFORE SUBSTITUTIONS WILL BE MADE:**

**A. FOR STUDENTS WITH A DISABILITY**

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

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\_\_\_\_\_self care \_\_\_\_\_seeing \_\_\_\_\_breathing \_\_\_\_\_performing manual tasks \_\_\_\_\_hearing \_\_\_\_\_learning \_\_\_\_\_walking \_\_\_\_\_speaking \_\_\_\_\_working \_\_\_\_\_other

**B. FOR STUDENTS WITHOUT A DISABILITY**

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

\_\_\_\_\_Diabetes Mellitus \_\_\_\_\_Reduced Calorie \_\_\_\_\_Increased Calorie

\_\_\_\_\_Modified Texture \_\_\_\_\_Food Allergy (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C: TO BE COMPLETED BY A LICENSED PHYSICIAN**

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.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Date phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Date phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Date phone

Revised May 2019[[1]](#endnote-1)

1. [↑](#endnote-ref-1)