

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:

\_\_\_\_\_

_____ <i>caring for one's self</i>	_____ <i>seeing</i>	_____ <i>breathing</i>
_____ <i>performing manual tasks</i>	_____ <i>hearing</i>	_____ <i>learning</i>
_____ <i>walking</i>	_____ <i>speaking</i>	_____ <i>working</i>
_____ <i>other:</i> _____		

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

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

\_\_\_\_\_

DateSignature of Physician

**Part III** (optional—to be completed when appropriate by a licensed Registered Dietitian (RD), Nurse (RN) or other health care team member)

INSTRUCTIONS GIVEN PARENTS REGARDING CHILD'S NUTRITIONAL NEEDS:

---

---

---

LIST THE NUTRITION MATERIALS GIVEN 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

---