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**

Child Nutrition Section

Arkansas Department of Education

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.)

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____
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____
____

_________________________________ _________________________________

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