CERTIFICATION OF DISABILITY FOR SPECIAL DIETARY NEEDS
LITTLE ROCK SCHOOL DISTRICT
CHILD NUTRITION DEPARTMENT

1501 Jones Street Little Rock, AR 72202 (501) 447-2450

PLEASE RETURN ORIGINAL FORM TO THE CHILD NUTRITION DEPARTMENT
All correspondence→ ATTN: Special Diets
Form will only be accepted if filled out by a licensed medical doctor

PART 1 (to be completed by school or parent/guardian) Today's date _____
School _____ Grade _____
Student's Name _____ID# _____ Age_____
Parent'/Guardian_____ Daytime Phone Number_____

PART 2 (to *be completed by a licensed medical doctor ONLY)*
Please CHOOSE A or B

A. FOR STUDENTS WITH A DISABILITY

Describe the disability and check the major life activity affected by the disability:

_____
_____

_____caring for self _____seeing _____breathing _____performing manual tasks
_____hearing _____learning _____walking _____speaking
_____working
_____other (Describe)_____

B. FOR STUDENTS WITHOUT A DISABILITY

Identify the medical condition/special dietary need requiring modification:

_____Diabetes ____Reduced Calorie ____Increased Calorie _____Modified Texture
_____Food Allergy (describe)_____
_____Other (describe)_____

PART 3 *(to be completed by a licensed medical doctor ONLY):*

Please list the food(s) to be omitted from the child's diet and the food(s) that may be substituted. **PLEASE BE SPECIFIC**. **Substitutions will be made only if listed below. Attach an additional sheet(s) if necessary.**

Food(s) to be avoided:	**Substitution(s):**
_____	_____
_____	_____
_____	_____

_____ _____ _____
Signature of Licensed Medical Doctor **Office phone number** **Today's date**

PART 4 (completed form to be reviewed and signed by the following):

_____ _____
Parent/ Guardian Date School Principal Date

_____ _____
School Nurse Date Cafeteria Manager Date

White Copy-Child Nutrition Dept. Yellow Copy-Cafeteria Manager Pink Copy-School Nurse

FOR CHILD NUTRITION DEPARTMENT USE ONLY: Date received/initials: _____Date entered: _____
Revised June 2012 ka