WARREN SCHOOL DISTRICT – CHILD NUTRITION PROGRAM
P.O. BOX 1210
WARREN, AR. 71671

Certification of Disability For Special Dietary Needs

Name of Student:_____

Birth Date:_____ **Grade:**_____ **Teacher:**_____

Telephone:_____ **Physician:** _____

For Physician's Use:
Identify and describe disability or medical condition, including allergies that require the student to have a special diet. Describe the major life activities affected by the student's disability.

_____
_____
_____

Diet Prescription (check all that apply):

- _____ **Diabetic (attach meal/snack plan with carbohydrate distribution)**
- _____ **Reduced Calorie (attach meal plan):**_____
- _____ **Increased Calorie (attach meal plan):**_____
- _____ **Modified Texture and/or liquids:**_____
- _____ **Low Sodium/Low Salt:**_____
- _____ **Food Allergy (describe):**_____
- _____ **Other (describe):**_____

Check food groups to be omitted:

- _____ **Meat & Meat Alternates**
- _____ **Bread & Cereal Products**
- _____ **Fruits & Vegetables**
- _____ **Fluid Milk Only**
- _____ **Milk & Milk Products**

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary. (Example: Fluid milk omitted, juice to be substituted)

OMITTED FOODS	SUBSTITUTIONS
_____	_____
_____	_____
_____	_____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____	_____	_____
Licensed Physician Signature	**Office Phone Number**	**Date**