DIET PRESCRIPTION for MEALS at SCHOOL

Student's Name Age

School Grade/Classroom

Parent’s Name

Address Telephone

 Street or P. O. Box City State

Does the student have a disability that requires a special diet? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

If Yes, describe the major life activities affected by the disability on back.

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If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

**Diet Prescription** (Check all that apply.):

\_\_\_\_ Diabetic \_\_\_\_ Increased Calorie \_\_\_\_\_\_\_\_\_\_#kcal

\_\_\_\_ Food Allergy \_\_\_\_ Reduced Calorie \_\_\_\_\_\_\_\_\_\_\_#kcal

\_\_\_\_ Hypoglycemic \_\_\_\_ Texture Modification

 Chopped\_\_\_\_ Ground\_\_\_\_\_\_\_

\_\_\_\_ PKU Pureed\_\_\_\_\_\_ Liquefied\_\_\_\_\_\_

\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Tube Feeding

 Liquefied Meal Formula\_\_\_\_\_

**Foods Omitted and Substitutions**

(Please check food groups to be omitted. Identify specific foods to omit and list foods to be substituted. If necessary, attach additional information or instructions regarding the diet or feeding.)

 **Food Groups to Omit** \_\_\_\_ Meat and Meat Alternatives \_\_\_\_ Milk and Milk Products

 \_\_\_\_ Bread and Cereal Products \_\_\_\_ Fruits and Vegetables

**Specific Foods to Omit** **Specific Foods to Substitute**

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. **MUST BE SIGNED BY A DOCTOR**

 Office Telephone # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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