Diet Prescription for Meals at School

Date: Name of Student:

LEA: School Attended by Student:

*Information below to be completed by recognized medical authority.*

# Disability or medical condition that requires the student to have a

**special diet.** Include a brief description of the major life activity affected by the student’s disability.

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

 □ Diabetic □ Reduced Calorie

 □ Increased Calorie □ Modified Texture

□ Other (Describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Foods Omitted** (Please check food groups to be omitted.)

 □ Meat and Meat Alternates □ Milk and Milk Products

 □ Bread and Cereal Products □ Fruits & Vegetables

□ Other (Describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substitutions** (Please provide suggested substitutions for omitted foods or attach information.)

Textures Allowed (Check the allowed texture)

 □ Regular □ Chopped □ Ground □ Pureed

**Other Information Regarding Diet or Feeding** (Please provide additional information on the back of this form or attach to this form.)

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Physician/Recognized Medical Authority Signature Office Phone # Date

\*It is recommended that the diet prescription be renewed annually.