

**LOUISIANA DEPARTMENT OF EDUCATION
SCHOOL FOOD SERVICE SECTION
PROTOTYPE – 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.
(See back of form for further information.)

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

Diet Prescription (Check all that apply.):

- Diabetic
- Food Allergy
- Hypoglycemic
- PKU
- Other _____
- Increased Calorie _____ #kcal
- Reduced Calorie _____ #kcal
- Texture Modification
 - Chopped _____ Ground _____
 - Pureed _____ Liquefied _____
- 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
- Bread and Cereal Products
- Meat and Meat Alternatives
- Fruits and Vegetables
- Milk and Milk Products

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.

Office Address _____ Office Telephone # (____) _____

¹Licensed Physician/Recognized Medical Authority Signature

Date

¹Signature of Licensed Physician required if the student is disabled.