Steilacoom Historical School District No. 1
511 Chambers Street
Steilacoom, WA 98388
Telephone: (253) 983-2544 Fax: (253) 584-7198

Dietary Prescription for Student with Disability

Student's Name:_____Birthdate: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Name:_____ Phone: _____

Address: _____ City: _____ State: WA Zip code: _____

Parent/Guardian Signature: _____ Date: _____

Diet Order- To be completed by the Physician

1. List student's disability: _____
   (Include Life-threatening allergies which cause immune system response to a particular food/ingredient/additive.)
2. What is the major life activity(s) affected?: _____
3. Describe how the disability restricts student's diet: _____
4. List all food(s) and/or milk to be omitted: _____
5. List all food(s) and/or milk to be substituted: _____
6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.): _____

   _____
7. Describe any other comments about the student's eating or feeding patterns: _____

   _____

Signature of Licensed Physician: _____ Date: _____

Printed Name of Licensed Physician: _____E-mail: _____

Address:_____Phone:_____