Bethel Public Schools Nutrition Services
Diet Prescription for Meals at School

Student Name: _____Date of Birth: _____ Age: ____

Name of School: _____ Grade: _____

Section A: To be completed by parent or guardian. Please check box(es) and sign below:

☐ I understand that if my child's medical or health needs change, it is my responsibility to notify my child's school nurse/health clerk and have a new Diet Prescription for Meals at School form completed.

☐ I give Nutrition Services permission to speak with the Physician or Authorized Medical Authority named below to discuss the dietary needs described below.

_____ _____ _____
Parent/Guardian Signature | Home Phone Number | Date Signed

Section B: To be completed by child's Physician / recognized Medical Authority (if describing a disability).

Does the child have a disability? ☐ Yes ☐ No
If yes, describe the major life activity affected by the disability _____
_____

Does the child have a non-disabling medical condition? ☐ Yes ☐ No
If yes, describe the medical condition _____
_____

Does the child have special nutritional or feeding needs? ☐ Yes ☐ No
If yes, describe the specific need _____
_____

If you answered YES to any of the questions above, complete Section C and return to the nurse/health clerk at the child's school.

Section C: **PHYSICIAN REQUEST** Diet Prescription:
(To be completed by the child's Physician or a recognized Medical Authority).

Note: For any food item to be omitted from diet, a substitute **must** be listed.

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____

Please attach additional instructions if necessary.

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

_____ _____
Health Care Provider Signature | Date Signed

Name: _____ Office Phone: _____ Fax:_____
Type or Print