



Diet Prescription (Allergies) for Meals at School

Give the completed form to the School Nurse

Section A: To be completed by the student's parent or guardian

Student Name _____ Date of Birth _____ Age _____

School _____ Grade _____

Will the student eat the School Breakfast? Yes No Will the student eat the School Lunch? Yes No

➡ If you answered **NO** to both of the above questions, **STOP**. Form is not required by Nutrition Services.

I understand that if my student's medical or health needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed. I authorize the school nurse to inform all necessary school staff of my child's food allergy.

Parent/Guardian Signature _____ Phone Number _____ Date Signed _____

I give Nutrition Services permission to speak with the below named Licensed Physician or Recognized Medical Authority to discuss the dietary needs described. _____
Parent/Guardian's Initials & Date

Section B: To be completed by a Licensed Physician when identifying a disability OR a Recognized Medical Authority (RMA) when identifying a non-disabling medical condition. For Diet Prescription purposes, a RMA includes a Licensed Physician, Doctor of Osteopathy, Licensed Physician's Assistant, ARNP or Licensed Naturopathic Physician.

Student's Diagnosis? _____

Is the student's diagnosis recognized by the ADA as a disability? Yes No

If YES, describe the major life activity affected by the disability _____

Does the student have a non-disabling medical condition or special nutritional or feeding need? Yes No

If YES, describe the condition or need _____

Diet Prescription – please attach additional instructions if necessary.

Foods to Omit*:

Foods to Substitute:

*If foods are listed to be omitted from the diet, **specifics** on foods to substitute **must** be provided.

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

Licensed Physician or Recognized Medical Authority Signature

Date

Name, including credentials (type or print)

Phone

Fax

School Nurse Received: _____
Initials & Date

School Cafeteria Received: _____
Initials & Date