Diet Prescription for Meals at School

This file is to be maintained for use within the school cafeteria

Student's Name: _____ School: _____

To be completed by a Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner

Student's Diagnosis (Optional): _____

Diet Prescription- please attach additional instructions if necessary. Be specific with instructions as this form is used to provide guidance for Child Nutrition Employees.

Food to Omit (Due to Allergy or Sensitivity)

Food(s) to Omit:	**Food(s) to Substitute**

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

Other Diet Modifications (Check all that apply)

Special Diet	Information Required
____ Modified Carbohydrate	Grams per meal (range)
____ Increased Calorie	Calories per meal (range)
____ Decreased Calorie	Calories per meal (range)
____ Modified Texture	Textures allowed (i.e., ground, pureed)
____Other	Instructions:
____ Other	Instructions:

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 health condition.

_____ _____

Licensed Healthcare Provider Signature Date

1/2023