DIET PRESCRIPTION FOR MEALS AT SCHOOL

NAME OF STUDENT for whom special meals are requested _____

Disability or medical condition that requires the student to have a special diet. Include a brief description of the major life activity affected by the student's disability.

Diet Prescription - ***check all that apply***

- ☐ DIABETIC
- ☐ INCREASED CALORIE
- ☐ OTHER - (Describe): _____
- ☐ REDUCED CALORIE
- ☐ MODIFIED TEXTURE

Foods Omitted and Substitutions *(Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions using the back of this form or attach information.)*

- ☐ Meat and Meat Alternates
- ☐ Bread and Cereal Products
- ☐ Milk and Milk Products
- ☐ Fruits and Vegetables

NOTES: _____

Textures Allowed:

- ☐ Regular
- ☐ Chopped
- ☐ Ground
- ☐ Pureed

NOTES: _____

Other information regarding diet or meals at school:

(Please provide additional information. Use back of form or attach to this form if needed)

_____

_____

Does this student have lactose intolerance? ☐ Yes ☐ No

Can student tolerate dairy products other than milk? ☐ Yes ☐ No

If yes, what items? _____

Does this student have a food allergy? - ***Mark all that apply***

Students with life threatening food allergies will require special tray preparation by the cafeteria staff.

- ☐ Peanuts
- ☐ Tree Nuts
- ☐ Wheat
- ☐ Soy
- ☐ Fish
- ☐ Shellfish
- ☐ Dairy
- ☐ Eggs
- ☐ Other

Please list any other food allergies: _____

Is this allergy life threatening? *(Example: does it require an epi-pen?)* ☐ Yes ☐ No

Describe the child's reaction when exposed to the allergen: _____

_____

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.

Recognized Physician/Medical Authority Signature	*Office Phone Number*	*Date*