Eunice Public Schools

Diet Prescription for Special Meals In the Child Nutrition Programs

(Breakfast, Lunch, Snacks)

Students Name________________________________ DOB__________________________

School______________________________________ Grade/Teacher___________________

Describe the student's disability or medical condition that requires the student to have a special diet:

____

____

Does the disability or medical condition restrict the student's diet? _________ Yes _________ No

If yes, list food(s) to be omitted from the diet and food(s) that may be substituted and/or any adjustments that need to be made to the texture of foods:

____

____

Is special eating equipment needed? If so, describe:

____

____

Is a Registered Dietitian or Licensed Nutritionist consulting with the patient? If so, please list name and telephone number: ____

Healthcare Provider Signature__________________________ Printed Name________________________

Telephone Number _______________ Fax Number_________________ Date___________________

Parent Signature___________________________________ Printed Name________________________

Telephone Number _______________ Cell Phone__________________ Date___________________

. . . .

School Nurse Signature___________________________________ Date_____________ Time__________