WAYNE COUNTY SCHOOL DISTRICT

Diet Prescription for Meals at School

Student's Name_________________________________ Date of Birth____________

School____________________________________ Teacher/Grade:___________

Does your child have a Food Allergy or Medical condition that requires a special diet? _________ Yes
_________ No

If marked yes, please describe the Specific Food Allergy(ies) and/or Medical Condition_____________

____

FOR PHYSICIAN USE ONLY

Identify and describe the food(s) allergy or medical condition that requires the student to have a Special Diet.____

____

List the Food or Foods to be Omitted from the child's diet___________________________________

____

List the Food or Choice of Foods to be Substituted____

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____

I certify that the above student needs a special school meal as described above due to the student's food allergy or chronic medical condition.

____ ____________________

Physician Signature **Date**

I hereby give permission for the school staff to follow the above stated Nutrition Plan.

____ ____________________

Parent Signature **Date**

Revised 3/21/2024