DIET PRESCRIPTION FORM FOR STUDENTS REQUIRING SPECIAL MEALS AND/OR ACCOMMODATIONS

Please note: This statement must be updated annually **and** when there is a change or discontinuance of a diet order.

Student's name_____ **Birth date**_____ **Gender** ☐M ☐F
School attended_____ **Grade**_____
Parent/guardian name_____ **Primary phone**_____ **Alternate Phone**_____
Physician/Medical Provider's Name_____ **Phone**_____

****FOR PHYSICIAN'S USE ONLY**** (TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL)

Indicate medical diagnosis necessitating food restriction, substitution, or special diet. _____

Check major life activities affected by the student's disability or medical condition (optional).

☐Caring for self ☐Eating ☐Performing manual tasks ☐Walking ☐Seeing ☐Hearing

☐Speaking ☐Breathing ☐Learning ☐Working ☐Other_____

☐Major bodily function (i.e. immune system, neurological, respiratory, circulatory, endocrine, &reproductive functions)

☐Life-threatening (Epinephrine required)

Diet prescription (check all that apply)

☐Food allergy (please specify all)_____

☐Diabetic (attach meal plan) ☐Calorie level (attach meal plan ☐Modified Texture (describe)_____

☐Other (describe)_____

OMITTED FOODS/BEVERAGES	ALLOWED SUBSTITUTIONS

☐ Please check here if additional food lists are included in the order.

****If milk allergy listed above in the omitted box, please specify fluid milk substitution:**_____
*****If lactose intolerance, please specify one of the following:**

☐ No fluid milk only (may have cheese, yogurt, pudding, ice cream, etc.)

☐ No milk products (no fluid milk, yogurt, cheese, pudding, ice cream, etc.)

☐ No milk products and no products prepared with milk (ie. no breads, desserts, or other products prepared with milk)

_____

PHYSICIAN/MEDICAL PROVIDER'S SIGNATURE DATE

PARENT/GUARDIAN: I understand it is my responsibility to instruct my child not to share food items or eat any food item except those prepared for him/her in our home or by the school according to these prescribed orders. I further authorize the above diet orders as prescribed.

Parent/Guardian Signature: _____ Date: _____

School Nurse: _____ Signature: _____ Date: _____

CNP Manager: _____ Signature: _____ Date: _____

CNP Coordinator: _____ Signature: _____ Date: _____