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Superintendent of Schools

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Assistant Superintendent for Instruction

TINA M. LANE
Assistant Superintendent for
Personnel and Student Services

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WATERTOWN CITY SCHOOL DISTRICT

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DIET PRESCRIPTION FOR MEALS AT SCHOOL 2024-2025

Name of Student: _____ School: _____ Grade: ____

Disability or Medical Condition:

Metabolic Diseases:

Celiac Disease (Gluten Allergy)

Diabetes (circle one: type I or type II)

Other: _____

Food Allergies:

Egg

Fish

Peanut

Shellfish

Tree nut

Soy

Wheat

Milk

Lactose Intolerance

Other: _____

Is this condition permanent or temporary? Permanent Temporary

If temporary, please give the length of time instructions are to be followed with explanation:

Diet Prescription: (check all that apply)

Celiac Disease (Describe) _____

Diabetes (Describe) _____

Allergies (Describe) _____

Other (Describe) _____

Foods Omitted: _____

Substitutions: _____

Other Information Regarding Diet or Feeding: (Please provide additional information on the back of this form or attach to this form)

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.

Physician Signature

Office Phone Number

Date

Print Physician's Name

Address

Watertown City School District is committed to building a caring culture
that fosters lifelong learners and responsible citizens.