WATERTOWN CITY SCHOOL DISTRICT

Our Children, Our Future!

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.