

Diet Prescription for Meals at School

This file is to be maintained for use within the school cafeteria.

Student's Name: _____

Name of School: _____

To be completed by a Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner

Student's Diagnosis(optional): _____

Major life activity affected by the disability: _____

Diet Prescription- **please attach additional instructions if necessary.** Be specific with instructions.

This form is used to provide guidance for cafeteria staff.

Foods to Omit (Due to Allergy or Sensitivity):

Food to Omit	Recommended Food(s) to Substitute

****If foods are listed to be omitted from the diet, specifics on foods to substitute **MUST** be provided.**

Other Diet Modifications (Check All that Apply):

Special Diet	Information Requested
<input type="checkbox"/> Modified Carbohydrate	Grams per meal (range)
<input type="checkbox"/> Increased Calorie	Calories per meal (range)
<input type="checkbox"/> Decreased Calorie	Calories per meal (range)
<input type="checkbox"/> Modified Texture	Textures Allowed (i.e. ground, pureed)
<input type="checkbox"/> Other (Please specify):	Instructions:
<input type="checkbox"/> Other (Please specify):	Instructions:

I certify that the above-named student needs special school meals prepared or served as described above because of the student's disability or chronic medical condition.

State Licensed Healthcare Professional Signature

Date

***It is recommended that the diet prescription be renewed annually.**

Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity* and sexual orientation*), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a complainant should:

complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

*The enclosed "nondiscrimination" language herein was added pursuant to the May 5, 2022, USDA memorandum. However, although included as currently required for audit compliance by the USDA, the State of Alabama objects to its **inclusion, applicability** and the **application** of this language due to currently legal pending challenges in the matter of The State of Tennessee, et al. v. USDA, et al., Case No. 3:22-cv-00257, and may be subject to change or removal.