St. Charles Parish Public Schools
Child Nutrition Programs
Diet Prescription Form

Student's Name: ________________________________ Age:___ DOB:_____ Student #___________

School: _______________________________ Grade:_________ Homeroom: ___________

Parent's Name: ____________________________Parent's E-mail__________________

Address:____ Telephone: ____________
(Street or P.O. Box) City Zip

1. Does the child have a disability? Yes or No If yes, describe the major life activities affected by the disability.
   ____
2. If the child is not disabled does the child have special nutritional or feeding needs? Yes or No
3. Does your child have an Epi-Pen for specific food or foods? Yes or No If yes, please list food or foods.____
4. Does the child have an IEP? Yes or No

<u>Please complete section below</u>:
Medical Condition:____
Diet Prescription: ____
(mark all that apply):

Food Intolerance (digestive System Response)
__Lactose Intolerance: Eliminate Fluid Milk Only
Substitute (circle) Water, Juice, Soy, Lactaid or other
Other Milk products to omit:___________________
__Soy
__Wheat
__Wheat (due to celiac Disease)
__ Other_________________________________

Food Allergy (Immune system response)
__Eggs
__Fish
__Milk
__Tree Nuts
__Peanuts
__Shellfish
__Soy
__Other: ________________________________

____Texture modification (circle one) Chopped Ground Pureed Liquefied
____Consistency (circle one) Soft and bite sized Minced and moist Extremely thick Moderately thick (liquidized) Slightly thick Other __________________

____Diabetic Diets "Carbohydrate Distribution" = Breakfast______Lunch_______Snack______(# of Carbs/meal)

Any Other Specific Dietary Need:____

Specific Foods to Omit	Specific Foods to Substitute

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

Office Address: ______________________________ Office Telephone:_____________
______________________________ Office Fax: __________________

____ Date______________
Licensed Physician/Recognized Medical Authority Signature

Revised 6/7/2021