Diet Prescription for Meals at School

Date: ___________________Name of Student: ______________________________________
LEA: __Phenix City Schools______School Attended by Student:___________________________

Information below to be completed by recognized medical authority.

Disability or medical condition that requires the student to have a special diet.

Include a brief description of the major life activity affected by the student's disability.

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Diet Prescription (Check all that apply)

- □ **Diabetic**
- □ **Increased Calorie**
- □ **Reduced Calorie**
- □ **Modified Texture**
- □ **Other (Describe)** ____

Foods Omitted (Please check food groups to be omitted.)

- □ **Meat and Meat Alternates**
- □ **Bread and Cereal Products**
- □ **Milk and Milk Products**
- □ **Fruits & Vegetables**
- □ **Other (Describe)** ____

Substitutions (Please provide suggested substitutions for omitted foods or attach information.)

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Textures Allowed (Check the allowed texture)

□ **Regular** □ **Chopped** □ **Ground** □ **Pureed**

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/Recognized Medical Authority Signature **Office Phone #** **Date**

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