

St. James Parish School System
Diet Prescription for Meals at School

****Special Diets will not be supplied and certain foods will not be substituted or omitted, until this form is filled out by an MD and approved by Child Nutrition Department.**** This document is in effect for the current school year and must be renewed annually. Please fax completed form to 225-258-8112.

Student's Name: _____ Age: _____ DOB: _____

School: _____ Grade: _____ Homeroom: _____

Parent's Name: _____ Parent's E-mail: _____

Address: _____ Telephone: _____

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(s): _____

PHYSICIAN MUST COMPLETE SECTION BELOW:

Medical Condition: _____

Diet Prescription: (mark all that apply):

Food Intolerance:

____ Eggs-PURE FORM ONLY

____ Milk- PURE FORM ONLY**

____ Milk and Dairy ONLY**

____ Soy- PURE FORM ONLY

____ Wheat- WHOLE/UNPROCESSED ONLY

____ Wheat (due to Celiac Disease)

____ Red Dye

**** Please note which may be served in place of milk:**

____ Juice ____ Water ____ Almond Milk ____ Pure Dairy Lactose Free Milk ____ Rice milk

****Is milk eliminated due to MILK ALLERGY ____ or LACTOSE INTOLERANCE ____?**

Allergies:

____ Eggs ____ Fish ____ Milk ____ Nuts ____ Peanuts ____ Shellfish ____ Soy ____ Other _____

Eliminate ALL foods that may contain any form of: _____

***If Allergy, what is the reaction?** _____

****Diabetic Diets** = Breakfast _____ Lunch _____ Snack _____ (# of Carbs/meal)

Any Other Specific Dietary Needs (Modified Texture, Tube Feedings, etc): _____

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: _____

Licensed Physician/ Medical Authority **PRINT**

Licensed Physician/ Medical Authority **SIGNATURE**

DATE

Guidelines and Requirements for Diet Prescription Forms for Special Diets and Allergies

These guidelines and requirements have been established to ensure the safety of students when medically necessary menu change must be implemented.

- A new Diet Prescription Form (DPF) **must** be completed every school year.
- Food services is not allowed to substitute food or alter the diet without this form. Prior to receiving this form, the parent may be required to send the student's meals to school.
- All sections **must** be filled out completely.
- The DPF **must** be signed by a Physician or Recognized Medical Authority (NP, PA, etc).
- The diet prescription **will not** be altered unless a form is updated by the physician.
- Food Allergies: Please provide specific information regarding foods to omit and substitute.
- If the student cannot have fluid milk, please document appropriate substitute. We can provide any of the options listed on the form.
- DPF **must** be complete before implemented at the school site.
- An Individualized Health Plan **will not** be written for Special Diets and Food Allergies until a School RN receives a Diet Prescription that is signed by a physician.
- Please fax, mail, or deliver the form to the child's school or fax to 225-258-8112.