



Diet Prescription for School Meals

Student Name: _____ School: _____ Grade: _____
 Date of Birth: _____ Parent/Guardian Name: _____
 Parent/Guardian Phone #: _____ Email: _____

To be completed by Medical Authority (*Medical Physician (M.D.), Physician Assistant (P.A.), Osteopathic Physician (D.O.), Advance Practice Registered Nurse (A.P.R.N.), Naturopathic Physician (N.D)*)

Medical condition or disability requiring a special meal, accommodation, or substitute:

According to the ADA Amendments Act of 2008, the term 'disability' means, with respect to an individual, "a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment."

Provide a description of the major life activities or bodily functions affected by the condition:

- Nausea Vomiting Diarrhea Itching Swelling Rash
 Wheezing/Cough Other:

Dairy: <input type="checkbox"/> Milk Allergy <input type="checkbox"/> Lactose Intolerance <input type="checkbox"/> Other: _____	
Foods to omit: <input type="checkbox"/> Fluid Milk <input type="checkbox"/> All ingredients containing milk <input type="checkbox"/> Cheese <input type="checkbox"/> Yogurt <input type="checkbox"/> Butter <input type="checkbox"/> Baked goods made with milk <input type="checkbox"/> Other, Specify:	Allowed Substitute: <input type="checkbox"/> Lactose-free milk <input type="checkbox"/> Plant-based milk alternatives <input type="checkbox"/> Dairy-free food options <input type="checkbox"/> Other, Specify:
Eggs: <input type="checkbox"/> Egg Allergy <input type="checkbox"/> Other: _____	
Foods to omit: <input type="checkbox"/> Eggs <input type="checkbox"/> Baked goods containing eggs <input type="checkbox"/> Other, Specify:	Allowed Substitute: <input type="checkbox"/> Egg-free protein options <input type="checkbox"/> Egg-free baked goods <input type="checkbox"/> Other, Specify:
Grains: <input type="checkbox"/> Wheat Allergy <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Gluten Intolerance <input type="checkbox"/> Other: _____	
Foods to omit: <input type="checkbox"/> Wheat <input type="checkbox"/> Condiments <input type="checkbox"/> Rye <input type="checkbox"/> Oats <input type="checkbox"/> Barley <input type="checkbox"/> Other, Specify:	Allowed Substitute: <input type="checkbox"/> Gluten-free alternative grains <input type="checkbox"/> Wheat-free alternative grains <input type="checkbox"/> Rice <input type="checkbox"/> Corn products <input type="checkbox"/> Other, Specify:

Peanuts/Tree Nuts: <input type="checkbox"/> Peanut Allergy <input type="checkbox"/> Tree Nut Allergy <input type="checkbox"/> Other: _____	
Foods to omit: <input type="checkbox"/> Peanuts & Peanut Butter <input type="checkbox"/> Peanut Oil <input type="checkbox"/> All Tree Nuts & Nut Butters <input type="checkbox"/> Other, Specify:	Allowed Substitute: <input type="checkbox"/> Soy butter <input type="checkbox"/> Sunflower seed butter <input type="checkbox"/> Nut-free protein options <input type="checkbox"/> Other, Specify:
Seafood: <input type="checkbox"/> Fish Allergy <input type="checkbox"/> Shellfish Allergy <input type="checkbox"/> Other: _____	
Foods to omit: <input type="checkbox"/> Crustaceans (crab, shrimp, lobster) <input type="checkbox"/> Mollusks (clam, mussel, oyster, scallop) <input type="checkbox"/> Finned Fish <input type="checkbox"/> Anchovy as an ingredient <input type="checkbox"/> Imitation fish/crab <input type="checkbox"/> Other, Specify:	Allowed Substitute: <input type="checkbox"/> Non-fish protein options <input type="checkbox"/> Other, Specify:
Soy: <input type="checkbox"/> Soy Allergy <input type="checkbox"/> Other: _____	
Foods to omit: <input type="checkbox"/> Soy Protein <input type="checkbox"/> Soy Lecithin <input type="checkbox"/> Other, Specify:	Allowed Substitute: <input type="checkbox"/> Soy-free options <input type="checkbox"/> Other, Specify:
Other Condition: _____	
Foods to omit: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Allowed Substitute: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Altered Texture	
<input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed	
Adaptive Equipment:	

Signature of Medical Authority & Credentials: _____

Printed Name: _____ Date: _____

Doctor's office phone number: _____

CNP Manager: _____ Date: _____

School Nurse: _____ Date: _____

Parent/Guardian: _____ Date: _____

This information may be shared with kitchen and administrative staff to accommodate the student in all school activities.

This institution is an equal opportunity provider.