

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  
\_\_\_\_\_

**Please complete section below:**

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: \_\_\_\_\_

\_\_\_\_\_  
Licensed Physician/Recognized Medical Authority Signature

NPI # \_\_\_\_\_

Date \_\_\_\_\_