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: _____

_____ NPI # _____ Date_____
Licensed Physician/Recognized Medical Authority Signature

Revised 5/6/2025