St. Charles Parish Public Schools
Child Nutrition Programs
Diet Prescription Form

Student's Name: ________________________________ DOB: _______ School: _________ Grade: _______
Homeroom Teacher: ______________________________
Parent's Name: ________________________________ Telephone: _________________________________
Physician's Name: ______________________________ Physician's Telephone: ________________________
Physician's Fax: _______________________________

1. Does the student have a disability? Circle – Yes or No
   If yes, describe major life activities affected by the disability:
   ____
   ____
2. Does the student have special nutritional or feeding needs? Circle – Yes or No
3. Does the student have an Epi-Pen for allergies to specific food(s)? Circle – Yes or No
4. Does the student have an IEP? Circle – Yes or No

Parent Signature: ___________________________ Date: ___________________
**This signature grants permission for release of information to/from physician and nurse and/or therapist relevant to my child's needs in the educational setting.

REMAINDER OF FORM MUST BE COMPLETED BY THE PHYSICIAN

Medical Condition: ____ ICD Code: ______________

Date of last swallow study (modified barium swallow study or FEES): _________. Please attach results if applicable.

Diet Prescription: ____

Solid Food Texture – check one: ___Regular ___Soft and Bite-Sized ___Minced and Moist ___Puree

Liquid Consistency – check one: ___Thin ___Mildly thick (nectar) ___Moderately thick (honey)

Mark all that apply:

Food Intolerance (Digestive System Response)
___ Lactose Intolerant
   Eliminate:
   Substitute: Circle – water, juice, soy, Lactaid or other
___ Soy
___ Wheat
___ Wheat (due to Celiac Disease)
___ Other: _________________________

Food Allergy (Immune System Response)
___ Eggs
___ Fish
___ Milk
___ Tree Nuts
___ Peanuts
___ Shellfish
___ Soy
___ Other: _________________________

Diabetic Diet: Carbohydrate Distribution – Specify # of carbs/meal
Breakfast = _______ Lunch = ______ Snack = ______

Other Specific Dietary Needs: ____

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.

_____________________________________ NPI #: ______________ Date: ______________
Licensed Physician / Recognized Medical Authority Signature

Revised 3/19/2026