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Assistant Superintendent for Instruction

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Assistant Superintendent for
Personnel and Student Services

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Assistant Superintendent of Operations
and Finance

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DIET PRESCRIPTION FOR MEALS AT SCHOOL 2026-2027

Name of Student: _____ School: _____ Grade: _____

Disability or Medical Condition:

Metabolic Diseases:

☐ Celiac Disease (Gluten Allergy)

☐ Diabetes (circle one: type I or type II)

☐ Other: _____

Food Allergies:

☐ Egg

☐ Fish

☐ Peanut

☐ Shellfish

☐ Tree nut

☐ Soy

☐ Wheat

☐ Milk

☐ Lactose Intolerance

☐ Other: _____

Is this condition permanent or temporary? Permanent Temporary

If temporary, please give the length of time instructions are to be followed with explanation:

Diet Prescription: (check all that apply)

___Dysphagia: ☐ Level 1 (Pureed) ☐ Level 2 (Mech. Soft) ☐ Level 3 (Advanced) ☐ Regular

___Thickened Liquids: ☐ Nectar Thick ☐ Honey Thick ☐ Pudding Thick

___Celiac Disease (Describe) _____

___Diabetes (Describe) _____

___Allergies (Describe) _____

___Other (Describe) _____

Foods Omitted: _____

Substitutions: _____

Other Information Regarding Diet or Feeding: (Please provide additional information on the back of this form or attach to this form) I certify that the above-named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Physician Signature

Office Phone Number

Date

Print Physician's Name

Address

Watertown City School District is committed to building a caring culture
that fosters lifelong learners and responsible citizens.