Mobile County Public Schools
Diet Prescription For Meals At School
(TO BE RENEWED EACH SCHOOL YEAR)

Name of student for whom special meals at school are requested:

Name ____________________ DOB __________ School ____________________

Disability or medical condition that requires the student to have a special diet. Include a brief description of the major life activity affected by the student's disability.

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Diet Prescription (check all that apply)

____ Diabetic ____ Reduced Calorie

____ Increased Calorie ____ Modified Texture

____ Other (Describe) ______________________________

Foods omitted and substitutions (Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions using the back of this form or attach information).

<u>Eggs</u>
____ Whole Eggs like Omelets
____ Eggs Cooked into Products

<u>Milk and Milk Products</u>
____ Lactose Intolerance
____ Milk Protein Allergy

____ Meat or Meat Alternates

____ Bread and Cereal Products ____ Fruits and Vegetables

Textures Allowed (check the allowed texture)

____ Regular ____ Chopped ____ Ground ____ Pureed

Medication (Benadryl, EpiPen, etc.) at school for FOOD ALLERGIES
Circle Appropriate Answer YES or NO

Please provide additional information regarding diet or feeding on the back of 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/Recognized Medical Authority Signature Office Phone Number Date

INCOMPLETE FORMS WILL NOT BE ACCEPTED

Mail To: Mobile County Public Schools
Food Service Department
P. O. Box 180069
Mobile, AL 36618
slognion@mcpss.com OR aarnold@mcpss.com
Or Fax To: 221-4377
Office Number: 221-4374

f:dietprescription