

# DIET PRESCRIPTION FOR MEALS AT SCHOOL

NAME OF STUDENT for whom special meals are requested \_\_\_\_\_

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.

Diet Prescription - **check all that apply**

<input type="checkbox"/> DIABETIC	<input type="checkbox"/> REDUCED CALORIE
<input type="checkbox"/> INCREASED CALORIE	<input type="checkbox"/> MODIFIED TEXTURE
<input type="checkbox"/> 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.*)

<input type="checkbox"/> Meat and Meat Alternates	<b>NOTES:</b> _____ _____ _____
<input type="checkbox"/> Bread and Cereal Products	
<input type="checkbox"/> Milk and Milk Products	
<input type="checkbox"/> Fruits and Vegetables	

Textures Allowed:

<input type="checkbox"/> Regular	<b>NOTES:</b> _____ _____ _____
<input type="checkbox"/> Chopped	
<input type="checkbox"/> Ground	
<input type="checkbox"/> Pureed	

Other information regarding diet or meals at school:  
(Please provide additional information. Use back of form or attach to this form if needed)

\_\_\_\_\_  
\_\_\_\_\_

Does this student have lactose intolerance?  Yes  No

Can student tolerate dairy products other than milk?  Yes  No

If yes, what items? \_\_\_\_\_

Does this student have a food allergy? - **Mark all that apply**

**Students with life threatening food allergies will require special tray preparation by the cafeteria staff.**

<input type="checkbox"/> Peanuts	<input type="checkbox"/> Fish	<input type="checkbox"/> Other
<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Shellfish	
<input type="checkbox"/> Wheat	<input type="checkbox"/> Dairy	
<input type="checkbox"/> Soy	<input type="checkbox"/> Eggs	

Please list any other food allergies: \_\_\_\_\_

**Is this allergy life threatening?** (Example: does it require an epi-pen?)  Yes  No

Describe the child's reaction when exposed to the allergen: \_\_\_\_\_

\_\_\_\_\_

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.

\_\_\_\_\_

Recognized Physician/Medical Authority Signature

\_\_\_\_\_

Office Phone Number

\_\_\_\_\_

Date