Diet Prescription for Meals at School

Date: __________________________ Name of Student: __________________________
School Attended by Student: __________________________

Information below to be completed by recognized medical authority.

**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)

- [ ] Diabetic
- [ ] Reduced Calorie
- [ ] Increased Calorie
- [ ] Modified Texture
- [ ] Other (Describe) __________________________________________________________

**Foods Omitted** (Please check food groups to be omitted.)

- [ ] Meat and Meat Alternates
- [ ] Milk and Milk Products
- [ ] Bread and Cereal Products
- [ ] Fruits & Vegetables
- [ ] Other (Describe) __________________________________________________________

**Substitutions** (Please provide suggested substitutions for omitted foods or attach information.)

**Textures Allowed** (Check the allowed texture)

- [ ] Regular
- [ ] Chopped
- [ ] Ground
- [ ] Pureed

**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/Recognized Medical Authority Signature  Office Phone #  Date