

Diet Prescription for Meals at School

School Year:

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)

- | | |
|---|---|
| <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 (Please check food groups to be omitted.)

- | | |
|--|---|
| <input type="checkbox"/> Meat and Meat Alternates | <input type="checkbox"/> Milk and Milk Products |
| <input type="checkbox"/> Bread and Cereal Products | <input type="checkbox"/> Fruits & Vegetables |
| <input type="checkbox"/> Other (Describe) _____ | |

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

Textures Allowed (Check the allowed texture)

- | | | | |
|----------------------------------|----------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Chopped | <input type="checkbox"/> Ground | <input type="checkbox"/> 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