Revised 2016

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**

❑ **DIABETIC** ❑ **INCREASED CALORIES** ❑ **REDUCED CALORIES** ❑ **MODIFIED TEXTURE**

❑ **OTHER – (Describe):** _____

Foods Omitted and Substitutions *(Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions.)*

❑ Milk and Milk Products ❑ Meat and Meat Alternates ❑ Bread and Cereal Products ❑ Fruits & Vegetables

Notes: _____

_____

Textures Modification Required (if applicable):

❑ Chopped ❑ Ground ❑ Pureed ❑ Other

Notes: _____

_____

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

_____

_____

Is this student lactose intolerant? ❑ 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***

❑Peanuts ❑Tree Nuts ❑Wheat ❑Soy ❑Fish

❑Shellfish ❑Dairy ❑Eggs ❑Other

Please list other food allergies: _____

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

Does this student require special tray preparation by the cafeteria staff when allergens are present? ❑ Yes ❑ No.

Describe the student'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*