

CHILD NUTRITION DEPARTMENT DIET PRESCRIPTION FORM

DIET PRESCRIPTION REQUEST for MEALS at SCHOOL

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Grade/Classroom \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Street or P.O. Box City State

Does the student have a disability that requires a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, describe the major life activities impacted by the disabling condition (ex: walking, learning breathing, etc.)  
\_\_\_\_\_

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.  
\_\_\_\_\_

Diet Prescription (Check all that apply):

- Diabetic \_\_\_\_\_ #kcal
- Food Allergy
- Hypoglycemic
- Increased Calorie \_\_\_\_\_ #kcal
- Reduced Calorie \_\_\_\_\_ #kcal
- Texture Modification  
Chopped \_\_\_\_\_ Ground \_\_\_\_\_  
Pureed \_\_\_\_\_ Liquefied \_\_\_\_\_
- PKU
- Other \_\_\_\_\_
- Tube Feeding  
Liquefied Meal \_\_\_\_\_ Formula \_\_\_\_\_

Food Omitted and Substitutions

(Please check food groups to be omitted and list allowable food substitutes. If no items are checked, a list of omitted foods and a list of allowable foods are required. If necessary, attach additional information or instructions regarding the diet or feeding. For diabetic diets, a food exchange menu plan is required).

- Food Groups to Omit     Meat and Meat Alternatives     Milk and Milk Products  
 Bread and Cereal Products     Fruits and Vegetables

Specific Foods to Omit

Specific Foods to Substitute

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

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

I certify that the above named student requests special school meals prepared as described above and with the attachments provided because of the student's disability or chronic medical condition. **I understand this diet request will be evaluated by the Child Nutrition Department. A determination will be made as to whether or not substitutions will be made. Until such determination is made, parents may be required to send their child's meals to schools. This diet prescription request will expire at the end of this school year.**

Office Address \_\_\_\_\_ Office Telephone \_\_\_\_\_

\_\_\_\_\_  
Licensed Physician/Recognized Medical Authority Signature

\_\_\_\_\_  
Print Name of Licensed Physician/Recognized Medical Date

Date Diet Received:

By: