WEST BATON ROUGE PARISH SCHOOLS
CHILD NUTRITION PROGRAM
DIET PRESCRIPTION FOR MEALS AT SCHOOL

School Year 2019 - 2020
This document is in effect until May 31, 2020

Student's Name_____ Age_____

School_____ Grade/Homeroom_____

Parent's Name: _____ Parent's E-mail_____

Address:_____ _____
(Street or P.O. Box) City Zip

Telephone Number: Cell: _____ Home:_____ Work: _____

1. Does the child have a disability or IEP/IAP on file? **Yes or No** If yes, describe the major life activities affected by the disability. _____
   _____
2. If the child is not disabled does the child have special nutritional or feeding needs? **Yes or No** List the medical condition that requires special nutritional or feeding needs._____
   _____
3. Does your child have an Epi-Pen for specific food or foods? **Yes or No** If yes, please list the food or foods._____

List Disability/Medical Condition:_____

Diet Prescription (check all that apply):

	Carbohydrate Grams	*Carbohydrate Grams*
☐ **Diabetic:** Carbohydrate Counting	_____Breakfast	_____Lunch
OR		
☐ **Lactose Intolerance** (eliminate fluid milk):		
Other dairy is allowed: cooked cheese, etc.	_____Yes	_____No
Please document substitute for Fluid Milk:	_____Juice	_____Water

☐ **Texture Modification:** _____Diced _____Chopped _____Ground
_____**Pureed (check one):** ☐ Milk-like ☐ Nectar-like ☐ Honey-like ☐ Pudding-like

☐ **Other Diet Prescription:**_____

FOOD INTOLERANCE
(digestive system response)
Level I – eliminate intolerable food only

- ☐ Milk (fluid form only) – cheese allowed
  Substitute: ☐ Juice ☐ Water
- ☐ Milk and Dairy Products
- ☐ Eggs
- ☐ Wheat
- ☐ Soy
- ☐ Other:_____

FOOD ALLERGY
(immune system response)
Level II – eliminate products with food allergen

☐ Milk	☐ history of inhalation reaction
☐ Eggs	☐ history of inhalation reaction
☐ Fish	☐ history of inhalation reaction
☐ Shellfish	☐ history of inhalation reaction
☐ Tree Nuts	☐ history of inhalation reaction
☐ Peanuts	☐ history of inhalation reaction
☐ Wheat	☐ history of inhalation reaction
☐ Soy	☐ history of inhalation reaction

☐ Other:_____

I certify that the student named above needs special diet accommodations prepared as described related to the student's medical condition.

Office Address: _____ Office Telephone:_____
_____ Office Fax: _____

_____ Date_____
Licensed Physician/Recognized Medical Authority Signature

Guidelines and Requirements For
Diet Prescriptions for Meals at School

These guidelines and requirements have been established to ensure the safety of students when medically necessary menu change must be implemented.

- A new Diet Prescription Form **Must** be completed **every year**.
- Diet prescription forms must be filled out completely.
- Diet prescription form **Must** be signed by Physician/recognized Medical Authority.
- Diet Prescription forms will not be altered unless the Diet Prescription Form is updated by the physician.
- Diabetic Meal Plans: include the number of carbohydrates for each meal and snack. Must be monitored by school nurse.
- Food Allergens: include specific and detailed information regarding foods to omit and substitute.
- If the student cannot have fluid milk, please document appropriate substitute.
- Diet Prescription Forms **Must** be completed before implemented at school site.
- Menu substitutions will be provided at the discretion of the Child Nutrition Services Office according to current food availability.
- Please allow 5 days for processing in Central Office. Parent/Guardian will need to provide breakfast and/or lunch during this time. Please fax, mail or deliver the form to the school cafeteria or West Baton Rouge Parish Child Nutrition Department 3761 Rosedale Road, Port Allen, LA 70767, Phone # (225)343-8309 Fax # (225)389-0812 or email mary.couty@wbrschools.net .
- If the student has a **Food Intolerance (digestive system response) – Level I**, Check the foods that apply. The indicated allergen foods will be eliminated from the student's meal tray if it's whole form. (Example: The student has an intolerance to eggs; the student will not be served whole eggs such as scrambled eggs, hard boiled eggs, etc.)
- If the student has **Food Allergy (immune system response) – Level II**, check the foods that apply. The indicated allergen foods will be eliminated from the student's meal tray in its whole form as well as any food that contains the allergen food as an ingredient. (Example: The student has an allergy to eggs, the ingredient listing will be reviewed for eggs and any foods containing eggs will be eliminated from the student's meal tray). Please indicate if the student has a history of inhalation induced anaphylaxis reaction to the specified allergen.
- Confirmation of process completion will be sent to parent/guardian via contact number/e-mail provided.

Definition of Disability

- **Student with disabilities** means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.
- **Physical or mental impairment** means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems:
  Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.
- **Major life activities** means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.