Diet Prescription For Meals At School

Name of student for whom special meals at school 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
- ☐ REDUCED CALORIE
- ☐ INCREASED CALORIE
- ☐ MODIFIED TEXTURE
- ☐ OTHER (DESCRIBE) _____

FOODS OMITTED AND SUBSTITUTIONS (Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions using the back of this form or attach information.)

- ☐ MEAT AND MEAT ALTERNATES
- ☐ MILK AND MILK PRODUCTS
- ☐ BREAD AND CEREAL PRODUCTS
- ☐ FRUITS AND VEGETABLES

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 Number | Date