Department of Food and Nutrition

Diet Prescription for Meals at School

Part I (to be filled out by parent or guardian)

Name of Student: _____ Date of Birth: _____ Age: _____
(Last) *(First)* *(MI)*

School: _____

Name of Parent/Guardian(s): _____

Parent/Guardian(s) Daytime Phone No.: _____ _____ _____
Parent/Guardian's Signature

Part II (to be filled out by the physician)

Name of Student _____ requires special meals at school.

Patient's diagnosis: _____

Brief description of patient's condition related to the meal for diet modification: _____

_____

_____

_____

_____

Diet Prescription (check all that apply)

☐ Texture Modification:

- ☐ Pureed
- ☐ Ground
- ☐ Chopped

Foods Omitted and Substitutions (please check specific foods to be omitted and suggest substitution).

☐ Nuts ☐ Milk ☐ Wheat ☐ Peanuts ☐ Fish ☐ Mollusks
☐ Eggs ☐ Soybean ☐ Cheese ☐ Chicken ☐ Shellfish ☐ Other: _____

Specific Food Substitution: _____

_____

_____

_____

_____

I certify the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____ _____ _____ _____
Physician's Name (please print) Physician's Signature Office Phone No. Date

This form is valid for up to one year from evaluation date, but may be updated as determined by the physician.

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