

Diet Prescription for Meals at School

This file is to be maintained for use within the school cafeteria.

Student's Name: _____

Name of School: _____

To be completed by a Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner

Student's Diagnosis (optional): _____

Major life activity affected by the disability _____

Diet Prescription- please attach additional instructions if necessary. Be specific with instructions. This form is used to provide guidance for cafeteria staff.

Foods to Omit (Due to Allergy or Sensitivity)

Food to Omit: <div style="border: 1px solid black; height: 20px; width: 90%; margin-top: 5px;"></div>	Food(s) to Substitute: <div style="border: 1px solid black; height: 20px; width: 90%; margin-top: 5px;"></div> <div style="border: 1px solid black; height: 20px; width: 90%; margin-top: 5px;"></div> <div style="border: 1px solid black; height: 20px; width: 90%; margin-top: 5px;"></div>
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If foods are listed to be omitted from the diet, specifics on foods to substitute **MUST be provided.

Other Diet Modifications (Check All that Apply):

Special Diet	Information Required
<input type="checkbox"/> Modified Carbohydrate	Grams per meal (range)
<input type="checkbox"/> Increased Calorie	Calories per meal (range)
<input type="checkbox"/> Decreased Calorie	Calories per meal (range)
<input type="checkbox"/> Modified Texture	Textures Allowed (i.e. ground, pureed)
<input type="checkbox"/> Other (Please specify):	Instructions:
<input type="checkbox"/> Other (Please specify):	Instructions:

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

State Licensed Healthcare Professional Signature

Date

*It is recommended that the diet prescription be renewed annually.