Diet Prescription for Meals at School

Date: ___________________________  Name of Student: ___________________________

LEA: ___________________________  School Attended by Student: ___________________________

Information below to be completed by recognized medical authority.

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 (Please check food groups to be omitted.)

☐ Meat and Meat Alternates  ☐ Milk and Milk Products

☐ Bread and Cereal Products  ☐ Fruits & Vegetables

☐ Other (Describe) __________________________________________

Substitutions (Please provide suggested substitutions for omitted foods or attach information.)

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 #  Date

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