DIET PRESCRIPTION FOR MEALS AT SCHOOL

Student's Name: ________________________________ School: ______________________________

Age: ________ Grade: ________ Parent/Guardian: ____

Disability: __________________ ***OR*** Non-Disabling Medical Condition: _________________________

Major Life Activity Affected: ____

Diet Prescription (check all that apply):

- ☐ Increased calories
- ☐ Decreased calories
- ☐ Diabetic
- ☐ Food Allergy: __________________
- ☐ Other:

- ☐ Texture Modification
- ☐ Chopped
- ☐ Ground
- ☐ Pureed

Foods to Omit:

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____

Foods to Substitute:

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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.

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Physician/Recognized Medical Authority Signature

Office Phone Number: ________________________________ Date: __________________________

7/09