Diet Prescription for Meals at School

Student Name________________________________________ Date of birth_______
School__________________________________________________ Grade________

Major life activity affected:____________________________________
or
Non-disabling medical condition:_______________________________

Diet prescription (check all that apply):

□ Increased calorie _____ kcal
□ Decreased calorie _____ kcal
□ Diabetic
□ PKU
□ Food Allergy
□ Other___________

□ Texture Modification
□ Chopped
□ Ground
□ Pureed
□ Liquefied
□ Tube Feeding
□ Liquefied Meal
□ Formula _____type

Foods to Omit:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Foods to Substitute:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

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.

X

Physician or Recognized Medical Authority Signature
Office phone number:________________________________________ Date:____________

Field Supervisor Signature___________________________________ Date:___________