

Diet Prescription for Meals at School

Date:
LEA:

Name of Student:
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.