

## 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	Recommended Food(s) to Substitute

**\*\*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.