

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 Assistance, Nurse Practitioner, or Registered Dietitian

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 Requested
<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 as described above because of the student's disability or chronic medical condition.

Healthcare Provider Signature & Credentials

Date

*It is recommended, but not required, that the diet prescription be renewed annually.