Diet Prescription for Meals at School

Date: 
Name of Student: 
LEA: 
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.*