# Diet Prescription for Meals at School

Date: Name of Student:
LEA: School Attended by Student:

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*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.