Diet Prescription for Meals at School

Student's name____________________________Age_____Grade____

Disablity____

Major life activity affected:____________________________________

or

Diet prescription (check all that apply):

- ❑ Increased calorie ________#kcal
- ❑ Decreased calorie ________#kcal
- ❑ Diabetic
- ❑ PKU
- ❑ Food Allergy
- ❑ Other_____________

- ❑ Texture Modification
  - ❑ Chopped
  - ❑ Ground
  - ❑ Pureed
  - ❑ Liquified
  - ❑ Tube Feeding
    - ❑Liquified Meal
    - ❑Formula ______type

Foods to Omit:

____
____
____
____
____

Foods to Substitute:

____
____
____
____
____

I certify that the above-named student needs special school meals prepared as described above because of the student's disability or chronic condition.

____

Physician or Recognized Authority Signature (circle)

Office phone number__________________Date________________________

CC: kitchen, school office, District Office Food Service