August 2019

DIET PRESCRIPTION FOR MEALS AT SCHOOL

NAME OF STUDENT for whom special meals are requested: _____

Medical condition that requires the student to have a special diet. Please include a brief description of the child's physical or mental impairment that is sufficient to allow the school to understand how it restricts the child's diet.

_____

_____

_____

Food Intolerances/Allergies

Foods to be omitted and substitutions *(Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions.)*

❑ Milk to Drink ❑ All Milk Products ❑ Meat & Meat Alternates ❑ Bread & Cereal Products ❑ Fruits & Vegetables

Notes: _____

_____

Is this student lactose intolerant (Soy Milk or Lactose Free Milk will be provided)? ❑ Yes ❑ No

If lactose intolerant, can student tolerate dairy products other than liquid milk? ❑ Yes ❑ No

If yes, what items? _____

Does this student have a food allergy? – ***Mark all that apply***

❑Peanuts ❑Tree Nuts ❑Wheat ❑Soy ❑Fish

❑Shellfish ❑Eggs ❑Dairy (Milk, Cheese, Yogurt) ❑Other

Please list Other food allergies if applicable: _____

Other information regarding diet or meals at school:

(Please provide additional information. Use back of form or attach to this form if needed)

_____

_____

Is this allergy life threatening? *(Example: does it require an epi-pen?)* ❑ Yes ❑ No.

Does this student require special tray preparation by the cafeteria staff when allergens are present? ❑ Yes ❑ No.

Describe the student's reaction when exposed to the allergen: _____

Texture Modifications

Textures Modification Required (if applicable):

❑ Chopped ❑ Ground ❑ Pureed ❑ Other

Notes: _____

_____

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.

_____ _____ _____

Recognized Physician/Medical Authority Signature *Office Phone Number* *Date*