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 Assistant, or Nurse Practitioner

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
☐ Modified Carbohydrate		Grams per meal (range**)**
☐ Increased Calorie		Calories per meal (range)
☐ Decreased Calorie		Calories per meal (range)
☐ Modified Texture		Textures Allowed (i.e. ground, pureed)
☐ Other (Please specify):	Instructions:	
☐ Other (Please specify):	Instructions:	

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

_____ _____

State Licensed Healthcare Professional Signature Date

***It is recommended that the diet prescription be renewed annually.**