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:	Food(s) to Substitute:

Food to Omit:	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 Required
☐ 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.