**Diet Prescription for Meals at School   
*Give the completed form to the School Nurse:***

**Section A:** **To be completed by the student’s parent or guardian.**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_\_ Age: \_\_\_\_\_\_\_

Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_

I understand that if my student’s medical or health needs change, it is my responsibility to notify nursing/nutrition services and have a new Diet Prescription for Meals at School form completed. I authorize the school nurse to inform necessary school staff of my child’s food allergy.

Parent/Guardian’s Signature Home Phone Number Date Signed

□ I give Nutrition Services permission to speak with the below name Licensed Physician or Recognized Medical Authority to discuss the dietary needs described.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/guardian’s initials and date)

**Section B:**   
**To be completed by a Licensed Physician when identifying a disability** OR **a Recognized Medical Authority (RMA) when identifying a non-disabling medical condition.** *For Diet Prescription purposes, a RMA includes a Licensed Physician, Doctor of Osteopathy, Licensed Physician’s Assistant, ARNP or Licensed Naturopathic Physician.*

Student Diagnosis

Is the student’s diagnosis recognized by the ADA as a disability? **Yes \_\_\_ No\_\_\_\_**

If yes, describe the major life activity affected by the disability

**Diet Prescription – please attach additional instructions**

List any dietary restrictions or special diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List foods to omit: List foods to substitute:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List foods that need the following changes in texture. If all foods need to be prepare in this manner indicate “All”

Cut or chopped \_\_\_\_\_\_ Finely ground \_\_\_\_\_ Pureed \_\_\_\_\_\_\_

List any equipment or utensils that are needed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensed Physician or Recognized Medical Authority Signature Date

Name, Including Credentials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_

**Section C:**

School Nurse: Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Data Entered in TITAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date & Initials Date & Initials

School Cafeteria: Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Director of Child Nutrition Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date & Initials Date & Initials