Send completed form to:
Seattle Public Schools
Nutrition Services, Administrative Dietitian
P.O. Box 34165 / MS 32-372 Seattle, WA 98124
Phone: 206-252-0675 Fax: 206-252-0664

Diet Prescription for Meals at School

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

Student's Name: ______________________ Date of Birth: ____________ Age: ________

Name of School: ______________________________ Grade: ______________

Will student eat Breakfast at School? ☐ **Yes** ☐ **No;** Will student eat Lunch at School? ☐ **Yes** ☐ **No**

➡ If you answered **No** to both of the above questions, **STOP**. Form is not required by Nutrition Services.

I understand that if my student's medical or health needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed.

______________________ ______________________ ______________________
Parent/Guardian's Signature Home Phone Number Date signed

☐ I give Nutrition Services permission to speak with the below named Licensed Physician or Recognized Medical Authority to discuss the dietary needs described. ______________________
(parent/guardian's initials and date)

Section B: **Recognized Medical Authority (RMA) must complete and sign this section.** *RMA is a state licensed health care professional authorized to write medical prescriptions under State law. In WA State this includes Medical Doctor, Doctor of Osteopathy, Physician's Assistant with prescriptive authority, ARNP or Licensed Naturopathic Physician.*

Student's 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 ______________________

Does the student have a <u>non-disabling</u> medical condition or special nutritional or feeding need? ☐ **Yes** ☐ **No**

If Yes, describe the condition or need ______________________________________

Diet Prescription- **please attach additional instructions if necessary.**

Foods to Omit:	**Foods to Substitute:**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

If foods are listed to be omitted from the diet, specifics on foods to substitute **<u>must</u> be provided.

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: ____________
Type or Print

For office use: Received: ______________ Fast Track coding: ______________________
Date & Initials
Date entered in Fast Track: ______________ ______________________