Diet Prescription Form for Meals at School

Section A: To be completed by a Parent or Guardian

Student Name: ______________________________ Date of Birth: ____________ Age: ____________

School Name: ______________________________ School Fax: ____________ Grade: ____________

Please indicate which meals your student will eat at school with the check boxes below:

Breakfast ☐ **Lunch** ☐ **Snack** ☐

I understand that if my student's medical or health needs change, it is my responsibility to notify the school nurse of this change and fill out a new Diet Prescription for Meals at School form

Parent/Guardian Signature: ______________________________ Date Signed: ____________

Parent/Guardian Printed Name: ______________________________ Phone Number: ____________

Parent/Guardian Address: ______________________________

Parent/Guardian Email: ______________________________

☐ By checking this box, I acknowledge that this gives Health Services permissions to share diagnosis information with Culinary Services and gives Culinary Services permission to speak with the below named Licensed Physician or Recognized Medical Authority to discuss the dietary needs described.
Parent/Guardian Initial ____________

Clinic Name: ____________________ Name of Physician: ____________________ Phone: ____________

Section B: To be completed by a Medical Professional

This section is 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, an RMA includes a Licensed Physician, Doctor of Osteopathy, Licensed Physician's Assistant, ARNP or Licensed Naturopathic Physician.

Student Diagnosis: ______________________________

Please indicate if the student has a non-disabling medical condition, special nutritional or feeding need by checking this box: ☐
If the box was checked, please describe the condition, special nutrition or feeding need in the space below:

____

Please indicate if the diagnosis is recognized by the American Disabilities Act (ADA) as a disability by checking this box: ☐
If the box was checked, please describe the major life activity affected by the disability in the space below:

____

Diet Prescription: Please attach additional instructions if necessary.

Allergy to:
Please check all that apply: ☐ Raw Ingredient ☐ Cooked/Baked Ingredient ☐ Ingredient Cooked/Baked into food

Foods to Omit	Foods to Substitute
____________________	____________________
____________________	____________________
____________________	____________________

If foods are listed to be omitted from the diet, **specifics on foods to substitute **must** be provided.*
USDA Child Nutrition Programs support access to healthy meals to all children, including children with disabilities who have special dietary needs. Under the law, a disability is an impairment which substantially limits a major life activity, which can include allergies and digestive conditions, but does not include personal diet preferences.

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/Recognized Medical Authority Signature: ______________________________ Date: ____________

Licensed Physician/Recognized Medical Authority Name, including credentials: ______________________________