

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:** 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'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 non-disabling 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.

<p><b>Foods to Omit:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Foods to Substitute:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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**\*\*If foods are listed to be omitted from the diet, specifics on foods to substitute must 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: \_\_\_\_\_ Date & Initials  
Fast Track coding: \_\_\_\_\_  
Date entered in Fast Track: \_\_\_\_\_  
Revised 9-09 ww