DIET PRESCRIPTION FORM FOR MEALS AT SCHOOL

Section A: To be completed by the parent or guardian of student.

Student Name: _____ Date of Birth: _____ Age: _____

Name of School: _____ Grade: _____

Please indicate which meals your student will eat at school by using the checkboxes below:

Breakfast ☐ **Lunch** ☐ **Snack** ☐

*If your child will not be eating the above meals at school, **STOP**; this 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 Signature_____ Date Signed: _____

Parent/Guardian Printed Name_____ Home Phone Number: _____

☐ *By checking this box, I acknowledge that this gives Nutrition Services permission to speak with the below named Licensed Physician or Recognized Medical Authority to discuss the dietary needs described.* **Parent/Guardian Initial** _____

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 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:

_____

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:

_____

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 **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/Recognized Medical Authority Signature: _____

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

Phone: _____Fax: _____Date Signed: _____