# Diet Prescription for Meals at School

This file is to be maintained for use within the school cafeteria.

Student's Name: ______________________________

Name of School: ______________________________

*To be completed by a Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner*

Student's Diagnosis (optional): ____________________________________________

Major life activity affected by the disability ___________________________________

**Diet Prescription**- please attach additional instructions if necessary. Be specific with instructions. This form is used to provide guidance for cafeteria staff.

**Foods to Omit (Due to Allergy or Sensitivity)**

| Food to Omit: | Food(s) to Substitute: |
| --- | --- |
| | |
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| | |

| Food to Omit: | Food(s) to Substitute: |
| --- | --- |
| | |
| | |
| | |

**If foods are listed to be omitted from the diet, specifics on foods to substitute **MUST** be provided.

**Other Diet Modifications (Check All that Apply):**

| Special Diet | Information Required |
| --- | --- |
| ☐ Modified Carbohydrate | Grams per meal (range) |
| ☐ Increased Calorie | Calories per meal (range) |
| ☐ Decreased Calorie | Calories per meal (range) |
| ☐ Modified Texture | Textures Allowed (i.e. ground, pureed) |
| ☐ Other (Please specify): | Instructions: |
| ☐ Other (Please specify): | Instructions: |

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.

________________________________________ ____________________

State Licensed Healthcare Professional Signature Date

*It is recommended that the diet prescription be renewed annually.