# Diet Prescription for Meals at School

School Year:
Name of Student:
School Attended by Student:

*Information below to be completed by recognized medical authority.*

**Disability or medical condition that requires the student to have a special diet.** Include a brief description of the major life activity affected by the student's disability.

**Diet Prescription** (Check all that apply)

□ Diabetic
□ Reduced Calorie
□ Increased Calorie
□ Modified Texture
□ Other (Describe) _____

**Foods Omitted** (Please check food groups to be omitted.)

□ Meat and Meat Alternates
□ Milk and Milk Products
□ Bread and Cereal Products
□ Fruits & Vegetables
□ Other (Describe) _____

**Substitutions** (Please provide suggested substitutions for omitted foods or attach information.)

Textures Allowed (Check the allowed texture)

□ Regular □ Chopped □ Ground □ Pureed

**Other Information Regarding Diet or Feeding** (Please provide additional information on the back of this form or attach to this form.)

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____ _____ _____

Physician/Recognized Medical Authority Signature  Office Phone #  Date