

Diet Prescription for Meals at School

Student

Name _____ Age _____

School _____ Grade _____

Disability _____

Major life activity affected _____ OR

Non-disabling medical condition _____

Diet prescription (check all that apply)

Increased calorie
_____ #kcal

Decreased calorie
_____ #Kcal

Diabetic

PKU

Food allergy

Other _____

Texture Modification

Chopped

Ground

Pureed

Liquefied

Tube Feeding

Liquefied meal

Formula _____ type

Foods to Omit

Foods to Substitute

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 or Recognized Medical Authority Signature Date

Office location _____ Phone number _____