BALDWIN COUNTY PUBLIC SCHOOLS
Building Excellence

since 1799

Health Services Department

Diet Prescription for Meals at School

Student's Name_____ School_____

Please list 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

☐ Food Allergies (describe)_____ _____

Foods Omitted and Substitutions (Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions using the back of this form or attach information).

☐ Meat and Meat Alternates ☐ Milk and Milk Products

No Fried Foods___
Baked Lean Meat___
Meat Alternates___

Skim Milk ☐ 2% Milk ☐ 1% Milk ☐ Other ☐ _____

☐ Bread and Cereal Products ☐ Fruits and Vegetables

☐ Peanuts and Peanut Products ☐ Other _____

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's Signature Office Phone Number Date