Building Excellence

Health Services & Child Nutrition Program

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.

Condition (Check any that apply)

____ Food Allergies/Intolerance ____Decreased Calorie Diet

____Diabetic ____Modified Texture Diet

____Increased Calorie Diet ____Celiac Disease

____PKU ____Other

Foods to Omit from School Meals -Please check food category to be omitted. List specific foods to be omitted.

____Wheat/Gluten ____Eggs (whole eggs) ____ All Foods made with Eggs

____Fruits ____Vegetables ____Animal Products/Meats

____Fluid Milk Only ____All Foods made with Milk ____Soy

____Peanuts ____Tree Nuts

____Other: _____

Suggested Food Substitutions: _____

_____

Specific 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 requires special school meals prepared as described above because of the student's medical condition or disability.

_____ _____

Physician's Signature Office Phone Number Date