# 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 Physician, Physician's Assistant, Nurse Practitioner, Dentist, Optometrist, or Podiatrist*

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 | Recommended Food(s) to Substitute |
|---|---|
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**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.