Give the completed form to the School Nurse:

Diet Prescription for Meals at School

Section A: **To be completed by the student's parent or guardian.**

Student's Name: _____ Date of Birth __/__/___ Age: _____
Name of School: _____ Grade: _____
Will student eat the school breakfast? Yes ___No ___ Will student eat the school lunch? Yes ____No____

➡ If you answered **No** to both of the above questions, **STOP**. Form is not required by Nutrition Services.

I understand that if my student's medical or health needs change, it is my responsability to notify nursing/nutrition services and have a new Diet Prescription for Meals at School form completed. I authorize the school nurse to inform necessary school staff of my child's food allergy.

_____ _____ _____
Parent/Guardian's Signature | Home Phone Number | Date Signed

□ I give Nutrition Services permission to speak with the below name Licensed Physician or Recognized Medical Authority to discuss the dietary needs decribed.

_____
(parent/guardian's initials and date)

Section B: **To be completed by a Licensed Physician when identifying a disability** OR **a Recognized Medical Authority (RMA) when identifying a non-disabling medical condition.** *For Diet Prescription purposes, a RMA includes a Licensed Physician, Doctor of Osteopathy, Licensed Physician's Assistant, ARNP or Licensed Naturopathic Physician.*

Student Diagnosis_____

Is the student's diagnosis recognized by the ADA as a disability? **Yes ___ No____**

If Yes, describe the major life activity affected by the disability_____

Diet Prescription – please attach additional instructions
List any dietary restrictions or special diet:
_____

List foods to omit: List foods to substitute:
_____ _____
_____ _____

List foods that need the following changes in texture. If all foods need to be prepare in this manner indicate "All"
Cut or chopped _____ Finely ground _____ Pureed _____
List any equipment or utensils that are needed_____

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.

_____ _____
Licensed Physician or Recognized Medical Authority Signature Date

Name, Including Credentials _____ Phone: _____ Fax _____

Section C:
School Nurse: Received: _____ Data Entered in TITAN: _____
Date & Initials Date & Initials
School Cafeteria: Received: _____ Resident School Dietitian/ Received: _____
Date & Initials Date & Initials