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 Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner* 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 **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.