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 Practioner 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 Requested**
☐ 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.

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(1) mail: U.S. Department of Agriculture
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(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

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