School District of Superior-Diet Prescription for Meals at School

Student's Name: ________________________________ Date of Birth: __________Age:______

Name of School: ____Grade:__________

Does the child have a disability? Yes_______ No_______

Disability: ____________________________________

Major activity affected: ____

Non-Disabling Medical Condition: ____

For Physician's Use Only

Identify and describe disability, or medical condition, including allegories that require the student to have a special diet. Describe the major life activity affected by the student's disability.

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____

Diet Prescription

____ Diabetic (include calorie level or attach meal plan).
____ Reduced Calorie______Level _____Food Allergy (describe) _________________
____ Increased Calorie ______Level _____Other (describe) ________________________
Food Omitted and Substitutes:
Use space to list food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.
OMITTED FOODS SUBSTITUTIONS

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____

Indicate Texture:
_____Regular _____Chopped _____Ground ____Pureed
Indicate Thickness of liquids:
_____Regular _____Nectar _____Honey ____Pudding
Additional Comments:

____

____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

____

Physician's Signature Telephone Number Date

____

Signature of Preparer Telephone Number Date

I hereby give permission for the school staff to follow the above stated nutrition plan.

____

Parent/Guardian Date
*Copy to Lunchroom Manager Copy to Central Office-School Foodservice Director