Logansport Community School Corporation

DIET PRESCRIPTION FORM

School Year: ____________

*__Indicates required field/must be completed.__

*Student's Name:____DOB:__________________________

*School:____GRADE:_________________________

*Parent/Guardian Name: ____

*Phone:______________________________ Email:____

I give Health Services/Nursing/Nutrition Services permission to speak with the Health Care Provider below to discuss my child's special dietary needs.

____

Parent/Guardian's Signature Date

*Diet Prescription (check one or more):

☐ **Diabetic** ☐**Calorie-Controlled** ☐**Other (describe):**________________________________

Texture Modification: ☐**Chopped** ☐ **Ground** ☐**Pureed**

☐ **Food Allergy (specify all):**____

[ ] Non-disabling (food sensitivity)

[ ] Disabling Allergy (includes severe and/or anaphylaxis)

*Major life activity affected by the student's **disability** (check one or more) do **not** check for sensitivity's:

☐ Caring for Self ☐ Hearing ☐ Learning
☐ Performing Manual Tasks ☐ Speaking ☐ Performing Manual Tasks
☐ Walking ☐ Breathing ☐ Other:______________________
☐ Seeing ☐ Eating

*Omitted Foods/Beverages	*Allowed Substitution(s)

Additional Orders/Recommendations (i.e. peanut-free lunch table, etc.):

____

____

***I certify that the above named student needs special meals prepared as described above because of the student's condition.**

____________________________ ____________________________ ______________ _______

Physician's Signature Physician's Printed Name Office Phone Number Date

PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE or fax to (574) 722-7634.
Questions? Contact Food Service Department at (574) 722-2911
An updated form must be provided every school year and for any changes in child's dietary needs.

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