Diet Prescription for Meals at School

Give the completed form to the School Nurse:

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 responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed. I authorize the school nurse to inform all 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 named Licensed Physician or Recognized Medical Authority to discuss the dietary needs described. _____

(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's 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 _____

Does the student have a non-disabling medical condition or special nutritional or feeding need? □ **Yes** □ **No**

If Yes, describe the condition or need _____

Diet Prescription **- please attach additional instructions if necessary.**

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____

If foods are listed to be omitted from the diet, **specifics on foods to substitute **must** be provided.

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: _____

Type or Print

School Nurse: Received: _____ Date Entered in WebSMARTT: _____

Date & Initials

School Cafeteria: Received: _____ _____

Date & Initials