Zapata County Independent School District
Child Nutrition Department
P.O. Box 158\Zapata, Tx. 78076
(956)765-6546 (956)765-5940

Special Diet Prescription Form for Meals at School

Note to Parents/Guardian: The district requires that all students who need a special meal for Breakfast or Lunch must do the following:

1. Present this form signed by parent or legal guardian **and also** by the prescribing physician. (**U.S. Physicians Only**)
2. Keep the diet prescription current by submitting a new form at the beginning of each school year.
3. To change diet order, we must have a written consent from the **parent or legal guardian and a written prescription from a physician.**

Name of Student______________________ D.O.B.______________ School Year:__________________

School______________________ Teacher_____________ Grade:_________ Cafeteria Mgr._______

Height:_____________________ Weight:_______________

List all disabilities, diagnosis, and medical conditions that require the student to have a special diet:____

FOR THE FOLLOWING PLEASE CHECK ALL THAT APPY:
Meals Needed: ❑Breakfast ❑Lunch

Therapeutic Diet Prescription: ❑Diabetic ❑Reduced Calorie ❑Ulcer ❑Increased Calorie ❑Other______

Calorie Level Desired: ❑1600 ❑1800 ❑2000 ❑2200 ❑2500 ❑Other_____________

Mechanically Altered Texture Allowed: ❑Regular ❑Chopped ❑Ground ❑Pureed

Foods omitted and substitutions. Please Check foods to be omitted; list specific foods to be omitted and suggest substitutions.

❑Meat and/or Meat Alternates
Omit:__________________
Substitute:_________________

❑Milk and Milk Products
Omit:_______________
Substitute:___________

❑Bread & Cereal Products
Omit:___________________
Substitute:_________________

❑Fruits & Vegetables
Omit:_______________
Substitute:___________

Other information regarding Diet or Feeding:____
____

Diet Expiration Date or Feeding:____________ Note: Prescription must be renewed at the beginning of the school year, unless an earlier expiration date is noted.

❑Resume Regular Meals in the cafeteria and **CANCEL** previous diet order.

____________________ ______________________ _______________ _______________
Print Name Signature of Physician(No stamp) Date Phone Number

To Be Completed By Parent or Guardian

We the parents, by signing below, authorize the Child Nutrition Department to serve our child the special diet listed above.
I_________________________ give permission for my child_________________________ to receive the special diet listed above as directed by Doctor_________________________.

____________________ ______________ __________________ _______________________
Parents/Guardian Signature Date Home Phone# Emergency Phone#

Note: Please attach a list of foods to be avoided, and a recommended diet.