East Allen County Schools
HEALTH SERVICES
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of student for whom special meals at school are requested: _____

School: _____ Grade: _____

List the disability or medical condition that requires the student to have a special diet. Include brief description of the major life activity affected by the student's disability

_____

_____

This condition is ☐ permanent ☐ temporary

If temporary, please give length of time instructions are to be followed with explanation:

_____

_____

Diet Prescription: (Check all that apply.)

☐ Diabetic (Describe) _____

☐ Reduced Calorie (Describe) _____

☐ Increased Calorie (Describe) _____

☐ Modified Texture (Describe) _____

☐ Allergies (Describe) _____

☐ Other (Describe) _____

Foods Omitted and Substitutions:

☐ Meat and Meat Alternate (nuts, beans), may substitute with: _____

  ☐ May allow item(s) cooked in food.

☐ Bread and Cereal (grains), may substitute with: _____

  ☐ May allow item(s) cooked in food.

☐ Milk/ Milk Products (includes ice cream), may substitute with: _____

  ☐ May allow item(s) cooked in food.

☐ Fruits and Vegetables, may substitute with: _____

  ☐ May allow item(s) cooked in food.

Other Information Regarding Diet or Feeding: (Please provide additional information on the back of this form or attach to this form.)

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____

Physician/Recognized Medical Authority Signature Office Phone Number Date

_____

Parent/Guardian Signature Date