

PROTOTYPE
DIET PRESCRIPTION FOR MEALS AT SCHOOL

LOUISIANA DEPARTMENT OF EDUCATION
SCHOOL FOOD SERVICE SECTION

DIET PRESCRIPTION for MEALS at SCHOOL

Student's Name _____ Age _____

School _____ Grade/Classroom _____

Parent's Name _____

Address _____ Telephone _____
Street or P. O. Box City State

Does the student have a disability that requires a special diet? Yes _____ No _____
 If Yes, describe the major life activities affected by the disability.
 (See back of form for further information.)

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

Diet Prescription (Check all that apply.):

_____ Chopped _____ Ground _____
 _____ Pureed _____ Liquified _____
 _____ Liquified Meal _____ Formula _____

Foods Omitted and Substitutions
 (Please check food groups to be omitted. Identify specific foods to omit and list foods to be substituted. If necessary, attach additional information or instructions regarding the diet or feeding.)

Food Groups to Omit

Bread and Cereal Products _____

Specific Foods to Omit	Specific Foods to Substitute
_____	_____
_____	_____
_____	_____

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.

Office Address _____ Office Telephone # (_____) _____

 Licensed Physician/Recognized Medical Authority Signature Date