PROTOTYPE
DIET PRESCRIPTION FOR MEALS AT SCHOOL

APPENDIX Q

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.):

- ☐ Diabetic
- ☐ Food Allergy
- ☐ Hypoglycemic
- ☐ PKU
- ☐ Other_____
- ☐ Increased Calorie _____#kcal
- ☐ Reduced Calorie _____#kcal
- ☐ Texture Modification
  - Chopped____ Ground_____
  - Pureed_____ Liquified_____
- ☐ Tube Feeding
  - 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 ☐ Meat and Meat Alternatives ☐ Milk and Milk Products
☐ Bread and Cereal Products ☐ Fruits and Vegetables

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