Diet Prescription for Meal Pick Up

Date: _______________________________ LEA: _______________________________

Name of Student: ___________________________ Preferred School Pickup: ________________

**Information below to be completed by recognized medical authority**

**Disability or medical condition that requires the student to have a special diet** - Include a brief description of the major life activity affected by the student’s disability

Diet Prescription (Check all that apply)

☐ Diabetic      ☐ Reduced Calorie
☐ Increased Calorie   ☐ Modified Texture
☐ Other (Describe)

**Foods Omitted (Please check food groups to be omitted.)**

☐ Meat and Meat Alternates   ☐ Milk and Milk Products
☐ Bread and Cereal Products   ☐ Fruits & Vegetables
☐ Other (Describe)

**Substitutions** *(Please provide suggested substitutions for omitted foods or attach information.)*

**Textures Allowed (Check the allowed texture)**

☐ Regular      ☐ Chopped      ☐ Ground      ☐ Pureed

**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  Date

*The diet prescription must be renewed annually.*