MONTGOMERY
PUBLIC SCHOOLS

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.***