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
▯ Bread and Cereal Products ▯ Fruits and Vegetables ▯ Meat and Meat Alternatives ▯ Milk and Milk 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 # (   ) ______________

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Licensed Physician/Recognized Medical Authority Signature Date