LOUISIANA DEPARTMENT OF EDUCATION
SCHOOL FOOD SERVICE SECTION

DIET PRESCRIPTION FOR MEALS AT SCHOOL

****Special Diets will not be supplied and certain foods will not be substituted or omitted, until this form is filled out by an MD and approved by Child Nutrition Department.****

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 on back.

_____
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_____ Liquefied_____
____ Tube Feeding
Liquefied 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
____ Meat and Meat Alternatives
____ Fruits and Vegetables
____ 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. **MUST BE SIGNED BY A DOCTOR**

Office Telephone # ( )_____ Date: _____

_____ _____

Licensed Physician/Recognized Medical Authority **PRINT** Licensed Physician/Recognized Medical Authority **SIGNATURE** Revised 4/2016