DIOCESE OF ALEXANDRIA
CHILD NUTRITION PROGRAM
DIET PRESCRIPTION FOR MEALS AT SCHOOL
Return completed form to cafeteria manager

Patient Information

Student's Name_____ Age_____
School_____ Grade_____
Parent's Name_____
Mailing Address _____
City_____ State_____
Telephone (____)_____

Disability

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 *Bulletin 1196 Section 727* for further information.)

Medical Condition

If the student is not disabled, check the medical condition that requires special nutritional or feeding needs. (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 To Be Omitted and Substitutions

Check the 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
( ) Fruits and Vegetables
( ) Milk and Milk Products
( ) Bread and Cereal 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 #

_____ _____
Licensed Physician/Recognized Medical Authority Signature Date
*Signature of Licensed Physician required if student is disabled.