

PROTOTYPE
DIET PRESCRIPTION FOR MEALS AT SCHOOL

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 _____

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 | ☐ Increased Calorie _____ #kcal |
| ☐ Food Allergy | ☐ Reduced Calorie _____ #kcal |
| ☐ Hypoglycemic | ☐ Texture Modification |
| | Chopped _____ Ground _____ |
| ☐ PKU | Pureed _____ Liquified _____ |
| ☐ Other _____ | ☐ 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 | ☐ Meat and Meat Alternatives | ☐ Milk and Milk Products |
| ☐ Bread and Cereal Products | ☐ Fruits and Vegetables | |

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