

**School District of Superior Foodservices
Diet Prescription for Meals at School**

Student's Name: _____ Date of Birth: _____ Age: _____
Name of School: _____ Grade: _____
Does the children have a disability? Yes _____ No _____ Disability: _____
Major activity affected: _____
Non-Disabling Medical Condition: _____

For Physician's Use Only

Identify and describe disability, or medical condition, including allergies that require the student to have a special diet. Describe the major life activity affected by the student's disability.

Diet Prescription

____ Diabetic (include calorie level or attach meal plan).
____ Reduced Calorie _____ Level _____ Food Allergy (describe) _____
____ Increased Calorie _____ Level _____ Other (describe) _____

Food Omitted and Substitutes:

Use space to list food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS SUBSTITUTIONS

Indicate Texture:

____ Regular _____ Chopped _____ Ground _____ Pureed

Indicate Thickness of liquids:

____ Regular _____ Nectar _____ Honey _____ Pudding

Additional Comments:

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature Telephone Number Date

Signature of Preparer Telephone Number Date

I hereby give permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian Date

Copy to Lunchroom Manager Copy to Central Office-School Foodservice Director