SECTION VIII – NON-INSTRUCTIONAL
(8000-25)

(Policy 8550.00)

PRESCRIPTION FOR MEALS AT SCHOOL

School Year _____

Student's Name: _____ Age: _____ Grade: _____

Disability: _____

Major Life Activity Affected: _____
OR
Non-disabling Medical Condition: _____

Diet Prescription (check all that apply):

- ☐ Increased Calorie - _____ # kcal
- ☐ Decreased Calorie - _____ # kcal
- ☐ Diabetic
- ☐ PKU
- ☐ Food Allergy
- ☐ Texture Modification
- ☐ Chopped
- ☐ Ground
- ☐ Pureed
- ☐ Liquified
- ☐ Tube Feeding
- ☐ Liquified Meal
- ☐ Formula _____ Type
- ☐ Other _____

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Typical Symptoms: _____

Emergency Treatment Plan: _____
_____

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.

_____	_____	_____
Physician or Recognized Medical Authority Signature (circle)	Office Phone Number	Date

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_____	_____	_____
Director of Student Nutrition Services	School Nurse	Director of Special Services (when student requires a 504 plan)

Copy to: School _____ Kitchen _____ SNS _____

(7-18-02)