

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
- Food Allergy
- Hypoglycemic
- PKU
- Other \_\_\_\_\_
- Increased Calorie \_\_\_\_\_ #kcal
- Reduced Calorie \_\_\_\_\_ #kcal
- Texture Modification  
Chopped \_\_\_\_\_ Ground \_\_\_\_\_  
Pureed \_\_\_\_\_ Liquified \_\_\_\_\_
- 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
- 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.

Office Address \_\_\_\_\_ Office Telephone # \_\_\_\_\_

Licensed Physician/Recognized Medical Authority Signature

Date