Special Diet Prescription for Meals

PART 1 – TO BE COMPLETED BY PARENT/GUARDIAN OR LOCAL AGENCY

Child's Name:_____ Birth Date:_____

School:_____

Parent/Guardian Name:_____

Parent/Guardian Home Phone:_____ Work Phone:_____

PART 2 – TO BE COMPLETED BY PHYSICIAN

Diagnosis:_____

_____

Describe the patient's disability and the major life activity affected by the disability:

_____

_____

Does the disability restrict the individual's diet: Yes____ No____

If yes, list food(s) to be omitted from the diet and food(s) that may be substituted (Diet Plan):

Foods to Omit: _____

_____

Foods to Substitute: _____

_____

I certify that the above named child needs special meals prepared as described above because of the child's disability or chronic medical condition.

_____ _____
Physician Signature Date

_____ _____
Clinic Phone Number Clinic Fax Number

_____Original to Child's File
_____Copy to Kitchen
_____Copy to Food Service Director