APPENDIX Q

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____________
Street or P. O. Box City State

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