Building Excellence
Health Services

DIET PRESCRIPTION FOR SCHOOL

Student's Name: _____ Date: _____

School/Number: _____ School Nurse: _____

Student's Diagnosis: _____ Allergies: _____

Foods to Omit (Due to Allergy or Sensitivity)

****If foods are listed to be omitted from the diet, specifics on foods to substitute MUST be provided. ****

Food to Omit:	Food(s) to Substitute:

Food to Omit:	Food(s) to Substitute:

Other Diet Modifications (Check All that Apply):

Special Diet	Information Required
☐ Modified Carbohydrate	Grams per meal (range)
☐ Increased Calorie	Calories per meal (range)
☐ Decreased Calorie	Calories per meal (range)
☐ Modified Texture	Textures Allowed (i.e. ground, pureed)
☐ Other (Please specify):	Instructions:
☐ Other (Please specify):	Instructions:

To be completed by a Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner

Please attach additional instructions if necessary. Be specific with instructions. This form is used to provide guidance for cafeteria staff.

I certify that the above-named student needs special school meals prepared or served as described above because of the student's disability or chronic health condition.

_____ _____

State Licensed Healthcare Professional Signature **Date**

This diet order is to be maintained for use within the school cafeteria.
It is recommended that the diet prescription be renewed annually.

02/2023