

**Houston County School Foodservices
Diet Prescription for Meals at School**

Student's Name: _____ Date of Birth: _____ Age: _____

Name of School: _____ Grade: _____

Does the children have a disability? Yes _____ No _____ Disability: _____

Major activity affected: _____

Non-Disabling Medical Condition: _____

For Physician's Use Only

Identify and describe disability, or medical condition, including allergies that require the student to have a special diet. Describe the major life activity affected by the student's disability.

Diet Prescription

_____ Diabetic (include calorie level or attach meal plan).

_____ Reduced Calorie _____ Level _____ Food Allergy (describe) _____

_____ Increased Calorie _____ Level _____ Other (describe) _____

Food Omitted and Substitutes:

Use space to list food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS

SUBSTITUTIONS

Indicate Texture:

_____ Regular _____ Chopped _____ Ground _____ Pureed

Indicate Thickness of liquids:

_____ Regular _____ Nectar _____ Honey _____ Pudding

Additional Comments: _____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature Telephone Number Date

Signature of Preparer Telephone Number Date

I hereby give permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian Date

Copy to Lunchroom Manager

Copy to Central Office-School Foodservice Director