

Complete and return to the school only if your child has a physician diagnosed food allergy.

## 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: \_\_\_\_\_

Cell Phone Numbers: \_\_\_\_\_

### 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

Medical Office Phone Number: \_\_\_\_\_

\_\_\_\_ Original to Child's File    \_\_\_\_ Copy to Kitchen    \_\_\_\_ Copy to Food Service Director/Dietitian    \_\_\_\_ Copy to School Nurse