ZACHARY COMMUNITY SCHOOLS
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Student Name _____ Age _____

School _____ Grade/ Homeroom _____

Parent _____ Telephone _____

Does the student have a disability that requires a special diet? ☐ Yes ☐ No
If yes, describe the major life activities affected by the
disability._____

_____

_____

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

_____

_____

_____

Diet Prescription (Check all that apply):

- ☐ Food Allergy
- ☐ Diabetes
- ☐ Hypoglycemic
- ☐ Increased Calorie _____ (# of Calories)
- ☐ Reduced Calorie _____(# of Calories)
- ☐ Texture Modification:
  - ☐ Chopped ☐ Ground ☐ Pureed ☐ Liquefied
- ☐ PKU
- ☐ Tube Feeding
  - ☐ Liquefied Meal ☐ Formula
- ☐ Other _____

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 Telephone _____

Physician's Signature

Fax _____