# Dietary Prescription for **Student WITH Disability**

## Child Nutrition Programs

**PARENT/GUARDIAN MUST COMPLETE THIS SECTION**

| Student Name | Birth Date | Age | Grade | School |
|---|---|---|---|---|
| | | | | |

| Parent/Guardian Name | Phone |
|---|---|
| | |

| Mailing Address | City/State/Zip |
|---|---|
| | |

| Signature of Parent/Guardian | Date |
|---|---|
| | |

**DIET ORDER – LICENSED PHYSICIAN MUST COMPLETE and SIGN THIS SECTION.**

1. List student's disability: _____
   (Include life-threatening allergies which cause an immune system response to a particular food/ingredient/additive.)

2. What is the major life activity(s) affected?

3. Describe how the disability restricts student's diet:

4. List all food(s) and/or milk to be <u>omitted</u>:

5. List all food(s) and/or milk to be <u>substituted</u>:

6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

7. Describe any other comments about the student's eating or feeding patterns:

| Signature of Licensed Physician | Date | E-mail | Phone |
|---|---|---|---|
| | | | |

| Printed Name of Licensed Physician | Address |
|---|---|
| | |

Form Date 6-30-10