

### Special Diet Prescription Form

This form must be fully completed and signed by a licensed physician for a child with a disability, and by a recognized medical authority for a child with a medical/dietary need in order for a student to receive modifications or substitutions to the regular school meals.

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Student Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

Diagnosis (es): \_\_\_\_\_ ICD-9 code(s): \_\_\_\_\_

Parent/guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Describe the Student's:     Disability                       Medical Condition  
That requires the student to have a special diet and the major life activity affected by the student's disability or Condition: \_\_\_\_\_

History of anaphylaxis reaction due to severe food allergy:     Yes             No  
(If yes, please provide documentation)

History of allergy testing to indicate food allergy:     Yes             No            Date: \_\_\_\_\_

List Food(s) to be omitted from the diet and food(s) that may be substituted:  
\_\_\_\_\_  
\_\_\_\_\_

Registered Dietitian consulting with the patient:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_