

### Special Diet Prescription Form

Please have this form completed and signed by a licensed physician for a child with a disability or 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

Intolerance to foods? If yes, which foods? \_\_\_\_\_

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

Omit: \_\_\_\_\_

Alternatives: \_\_\_\_\_

---

Registered Dietitian consulting with the patient:

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

Licensed Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

(Signature)

Licensed Physician: \_\_\_\_\_ Fax Number: \_\_\_\_\_

(Print Name)

Mailing Address: \_\_\_\_\_

***\*Provider, please return completed and signed prescription form to the School Nurse***

---