Jefferson County Board of Education
Diet Prescription for Meals at School

Student's Name_____ Name of School _____

*To be completed by a Licensed Physician, Licensed Physician's Assistant, or Nurse Practitioner

Student's Diagnosis (optional):_____

Major life activity affected by the disablility_____

Diet Prescription-please attach additional instructions if necessary. Be specific with instructions. This form is used to provide guidance to cafeteria staff.

Foods to Omit (Due to an Allergy or Sensitivity)

Food to Omit	**Recommended Food (s) to Substitute**

******If foods are listed to be omitted from the diet, specifics on foods to substitute **MUST** be provided.

Other Diet Modifications (Check All That Apply)

Special Diet	**Information Required**
☐ Modified Carbohydrate	Grams per meal (range)
☐ Increased Calorie	Calories per meal (range)
☐ Decreased Calorie	Calories per meal (range)
☐ Modified Texture	Textures Allowed (i.e. ground, pureed)
☐ Other (Please Specify)	Instructions:

I certify that the above named student needs special school meals prepared or served as described above because of a student's disability or chronic medical condition.

_____ _____

State Licensed Healthcare Professional Signature **Date**

***It is recommended that the diet prescription be renewed annually.**