Prescription for Special Diet/Meal at School
Physician Authorization Form

The U.S. Department of Agriculture's (USDA) nondiscrimination regulation (7 CFR 15b), as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to the regular school meal must be made for children who are unable to eat school meals because of their disabilities, when that need is **certified by a licensed physician**. However, when possible, Food & Nutrition Services will try to make substitutions for medically certified dietary needs, even if it does not qualify as a disability. After this form is returned to the student's school nurse, a special dietary note will be placed in the student's meal account. One form per student must be completed, as needed, for each school year.

Physician to Complete Sections A, B, C, & D

Name of Student _____   Date of Birth _____

School Name _____

SECTION A

Does the student have a disability? Yes _____ No _____ (*If **NO**, please complete section B.*)
(*If **YES**, please describe the major life activities affected by the disability.*)

If yes, does the student have special nutritional or feeding needs? Yes _____ No_____ (*If **YES**, please complete Section C and Section D.*)

SECTION B

If the student does ***NOT*** have a disability, does he/she have special nutritional or feeding needs? Yes _____ No _____
(*If **YES**, please complete Section C and Section D.*)

SECTION C

1) Provide the diet prescription:

2) List any allergies or food intolerances to avoid.

3) Indicate Texture Modification request

☐ None   ☐ Chopped   ☐ Ground   ☐ Pureed   ☐ Liquid   ☐ Tube Feed

4) Foods to be Omitted and Substitutions (*If applicable*)
Please list specific foods to be omitted and suggested substitutions—use extra pages if needed.

Food(s)/Beverage(s) to be Omitted	**Suggested Substitution(s)**
_____	_____
_____	_____
_____	_____

SECTION D

I certify that the above named student requires special school food as described above.

Physician's Signature _____   Date _____

Parent's Signature _____   Date _____

School Nurse's Signature _____   Date received _____

Cafeteria Manager's Signature _____   Date received _____