Rev. 7-2012

Food and Nutrition Services
Diocese of Lafayette

Diet Prescription for Meals at School (*Please Print*)

Student Name: _____ Age: _____

School: _____ Student ID Number: _____

Parents Name: _____

Address: _____ Phone: _____

Does the student have a disability that requires a special diet? Yes _____ No_____

If yes, describe the major life activities affected by the disability.

_____

_____

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs. Diet Prescription (check all that apply)

_____Food Allergy _____PKU _____Hypoglycemic _____Diabetic _____Other

(Description): _____

Specific Foods to Omit (Example: If milk is to be omitted does that also include cheese and pudding) List each food to be omitted:

_____ _____ _____

_____ _____ _____

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

Office Address: _____
Office Telephone: _____

_____ _____
Licensed Physician/Recognized Medical Authority Signature *Date*

Printed Authority's Name: _____