SFS – 59
Rev. 7/17

Food and Nutrition Services
Diocese of Lafayette
Diet Prescription for Meals at School

PLEASE PRINT

Student Name_____ Age_____
School _____ Grade_____
Parents Name_____
Address_____Phone_____
City_____ State_____ Zip_____
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 ___Increased/Decreased Calories

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 Physician's Name_____

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