Diet Prescription for Meals at School

School:______________________________ Age:________ Grade:______

Student's Name: ____

Food Allergy/Allergies:____

Reaction if ingested:____

Foods to Omit due to Allergy:	Foods to Substitute:
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

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.

____

Physician/Recognized Medical Authority Signature

Office Phone Number______________________________

Date:___________________________