Jordan School District

Diet Prescription for Meals at School

Students Name________________________ Age________ Grade______ School________________________

Date of Birth___________________________ Name of Parent or Guardian______________________________

Email_________________________________Parent or Guardian Phone # ______________________________

Disability____

If a disability is indicated, provide a brief description of the major life activity affected by the disability:

____

Or Non-disabling medical Condition____

Diet prescription, (check all that apply):

- ☐ Increased Calorie _________#Kcal
- ☐ Decreased Calorie_________#Kcal
- ☐ Diabetic
- ☐ PKU
- ☐ Food Allergy___________________
- ☐ Other__________________________

- ☐ Texture Modification
- ☐ Chopped
- ☐ Ground
- ☐ Pureed
- ☐ Liquefied
- ☐ Tube Feeding, Formula Type_______

Foods to omit:

____

____

____

____

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. (If a disability is indicated a licensed medical physician must sign this form.)

____

Physician or Recognized Medical Authority (circle one)

Doctor Office Phone Number______________________________ Date of visit____________________

Lunch Manager's Initials________________

Date Received____________ Nutrition Services Director Approval______________________________

File original at school and copy at the district office/ USDA is an equal opportunity provider and employer.

This information may be shared with the school nurse or other administrative staff to accommodate the student in all school activities.