

Special Diet Prescription Form

Please have this form completed and signed by a licensed physician for a child with a disability or a medical/dietary need in order for a student to receive modifications or substitutions to the regular school meals.

Date: _____

Student Name: _____ Student Number: _____

Date of Birth: _____ School: _____

Diagnosis (es): _____ ICD-9 code(s): _____

Parent/guardian: _____ Phone Number: _____

Describe the Student's **Disability** **Medical Condition** that requires the student to have a special diet and the major life activity affected by the student's disability or condition:

History of anaphylaxis reaction due to severe food allergy: Yes No
If yes, please provide documentation.

History of allergy testing to indicate food allergy: Yes No

Intolerance to foods? If yes, which foods? _____

List food(s) to be omitted from the diet and food(s) that may be substituted:

Omit: _____

Alternatives: _____

Registered Dietitian consulting with the patient:

Name: _____ Phone Number: _____

Licensed Physician: _____ Phone Number: _____
(Signature)

Licensed Physician: _____ FAX Number: _____
(Print Name)

Mailing Address: _____

****Provider, please return completed and signed prescription form to the School Nurse***

Copies to: Clovis School Nurse, Clovis Cafeteria Manager