

**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.

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If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

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**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:

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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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