HUDSON CITY SCHOOL DISTRICT FOOD SERVICE DEPARTMENT MEDICAL DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of student for whom special foods at school are required or to be excluded_____.

Disability or **medical condition** that **requires** the student to have a special diet. Include brief description of the major life activity affected by the student's disability, if applicable_____

_____.

Is this condition temporary or permanent?_____

If this restriction is for a food allergy, check all that apply:

Food(s) student is allergic to:_____

_____

Is this allergy for ingestion only?_____

Is this allergy related to touching the food?_____

Other than restriction, is there any other precaution we should consider in providing care for this student?_____

_____

_____

Foods to be omitted:_____

_____

If substitutions are allowed, describe_____

_____

Diet restrictions, if applicable

___Diabetic (describe)_____

___reduced calorie (describe)_____

___Increased caloric intake (describe)_____

___Modified texture (describe)_____

___Allergies (describe)_____

Please attach additional pertainent information regarding diet/feeding plan.

I certify that the above student needs special school meals prepared for a chronic medical condition or disability.

Practitioner's SIgnature:_____Office phone #_____

Print Practitioner's Name:_____

Pratitioner's Address:_____