Dietary Prescription for **Student WITH Disability**

North Mason School District
Child Nutrition Programs

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name _____ Birth Date _____ Age _____ Grade _____ School _____

Parent/Guardian Name _____ Phone _____

Mailing Address _____ City/State/Zip _____

Signature of Parent/Guardian _____ Date _____

DIET ORDER – LICENSED PHYSICIAN MUST COMPLETE and SIGN THIS SECTION

1. List student's disability: _____
   (Include life-threatening allergies which cause an immune system response to a particular food/ingredient/additive.)
2. What is the major life activity(s) affected?
3. Describe how the disability restricts student's diet:
4. List all food(s) and/or milk to be omitted:
5. List all food(s) and/or milk to be substituted:
6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree etc.):
7. Describe any other comments about the student's eating or feeding patterns:

Signature of Licensed Physician _____ Date _____ E-mail _____ Phone _____

Printed Name of Licensed Physician _____ Address _____

This institution is an equal opportunity provider and employer.