

Jordan School District

Diet Prescription for Meals at School

Students Name _____ Age _____ Grade _____ School _____

Date of Birth _____ Parent or Guardian Phone # _____

Email _____

Disability _____

Or

Non-disabling medical Condition _____

Diet prescription, (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Increased Calorie _____ #Kcal | <input type="checkbox"/> Texture Modification |
| <input type="checkbox"/> Decreased Calorie _____ #Kcal | <input type="checkbox"/> Chopped |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Ground |
| <input type="checkbox"/> PKU | <input type="checkbox"/> Pureed |
| <input type="checkbox"/> Food Allergy _____ | <input type="checkbox"/> Liquefied |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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.

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