LOS LUNAS SCHOOLS
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 codes(s): _____

Parent/Guardian: _____ Phone Number: _____

Describe the Student's Disability or 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/Practitioner Signature: _____

Phone Number: _____ Fax Number: _____

Print Name: _____

Mailing Address: _____

***Provider, please return completed and signed prescription form to School Nurse**
***Copies to: LLS School Nurse Cafeteria Manager**