Madison City Child Nutrition Program

Diet Prescription for Meals at School

Name of Student: _____

School Attending: _____

Information below to be completed by recognized medical authority.

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

Diet Prescription (Check all that apply)

□ Diabetic □ Reduced Calorie

□ Increased Calorie □Modified Texture

□ Other (Describe) _____

Foods Omitted (Please check food groups to be omitted.)

□ Meat and Meat Alternates □ Milk and Milk Products

□ Bread and Cereal Products □ Fruits & Vegetables

□ Other (Describe) _____

Substitutions (Please provide suggested substitutions for omitted foods or attach information.)

Textures Allowed (Check the allowed texture)

□ Regular □ Chopped □ Ground □ Pureed

Other Information Regarding Diet or Feeding (Please provide additional information on the back of this form or attach to this form.)

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/Recognized Medical Authority Signature Office Phone # Date