OSPI School Meal Programs

Dietary Prescription for Student WITH Disability

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 – RECOGNIZED MEDICAL AUTHORITY* MUST COMPLETE and SIGN THIS SECTION.

*Recognized Medical Authority: State licensed health care professional authorized to write medical prescriptions under State law

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 Recognized Medical Authority	Date	E-mail	Phone

Printed Name of Recognized Medical Authority _____ Address _____