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