CHILD NUTRITION PROGRAM
3000 North Sherwood Forest Drive, Bldg. A
Baton Rouge, Louisiana 70814
PHONE (225) 226-3624

EAST BATON ROUGE PARISH SCHOOL SYSTEM
CHILD NUTRITION PROGRAM
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Student's Name________________________________Age__________Date of Birth ________________________________

School____Grade/Classroom ________________________________

Parent's Name____Telephone cell (_____)________________________________

Address ____Telephone home (_____)________________________________
(Street or P. O. Box) Telephone work (_____)________________________________

City____ State___________Zip Code________________________________

School Nurse________________________________Office#: _________________ Fax #____________________________
Does the student have a disability that requires a special diet? Yes________ No_________
If yes, describe the major life activities affected by the disability.
____
If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.
____

Prescription (Check all that apply):

( ) Diabetic - Up to ___________Carbs. Per Meal

( ) Increased Calorie ______________#kcal

( ) Food Allergy
Severe: My child can not (check all that apply)
Smell ________ Touch _______

( ) Reduced Calorie _______________#kcal

( ) Hypoglycemic

( ) PKU

( ) **Texture Modification**
Chopped _______ Ground _______
Pureed _______ Liquified ______

( ) Other____

( ) Religious Reason:___________________________________

( ) **Tube Feeding**
Liquified Meal ______ Formula ______

<u>Foods Omitted and Substitutions</u>

Please check the food groups to be omitted. Identify specific foods to omit and list foods to be substituted. Attach additional information or instructions regarding the diet or feeding.

Food Intolerance: digestive system response
<u>Eliminate intolerable food only</u>
( ) Bread and Cereal (Wheat) Products
( ) Fruits and Vegetables
( ) Eggs-**straight or boiled**
( ) Milk **(fluid form only)- cheese allowed**
( ) Milk and Milk Products **(cooked products allowed)**

( ) Other:____
Specific Foods to Omit (<u>must be completed</u>)
____
____

Food Allergy; immune system response
<u>Eliminate products with food allergens</u>
( ) Bread and Cereal (Wheat) Products
( ) Fruit and Vegetables
( ) Eggs and Egg products
( ) Milk and Milk Products
( ) Seafood **(fish or shellfish)**
( ) Soy
( ) Other: ____
Specific Foods to Substitute (<u>must be completed</u>)
____
____

I certify that the student named above needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Office Address____________________________________ **Office Telephone #** ___________________________

____ ______________________________
[1]Licensed Physician/Recognized Medical Authority Signature Date
[1]Signature of Licensed Physician required if the student is disabled.

FAX TO: Fatrice Williams, RDN, LDN at 225-275-2298

Definition of Disability

Definitions

As used in this part, the term or phrase:

(l) ***Student with disabilities*** means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.
(j) ***Physical or mental impairment*** means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems:
Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term *physical or mental impairment* includes but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.
(k) ***Major life activities*** mean functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working

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(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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