



**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.

(See back of form for further information.)

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 () Reduced Calorie _____ #kcal

Severe: My child can not (check all that apply)

Smell _____ Touch _____

() Hypoglycemic

() Texture Modification

Chopped _____ Ground _____
 Pureed _____ Liquified _____

() PKU

() Tube Feeding

Liquified Meal _____ Formula _____

() Other _____

() Religious Reason: _____

Foods Omitted and Substitutions

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

Eliminate intolerable food only

- () 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 (must be completed)

Food Allergy; immune system response

Eliminate products with food allergens

- () 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 (must be completed)

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 # _____

¹Licensed Physician/Recognized Medical Authority Signature

Date

¹Signature of Licensed Physician required if the student is disabled.

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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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