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 ______

OSPI School Meal Programs

Dietary Prescription for **Student WITHOUT Disability**

IS THIS REQUEST FOR COWS MILK SUBSTITUTION (check box): Yes ☐ No ☐

FOR INTERNAL INFORMATION ONLY: If yes, the local education agency must request approval from the Office of Superintendent of Public Instruction - Child Nutrition Services prior to making milk substitutions and must follow USDA regulations. Requests for milk substitutions may be signed by a parent/guardian OR recognized medical authority for students without disabilities.

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. What is the student's special dietary need?

2. List all food(s) to be omitted:

3. List all food(s) to be substituted:

4. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

5. 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 ______________________