LOS LUNAS SCHOOLS
SPECIAL DIET PRESCRIPTION FORM

Please have this form completed and signed by a licensed physician for a child with a disability or a medical/dietary need in order for a student to receive modifications or substitutions to the regular school meals.

DATE:_______________

STUDENT NAME:____STUDENT NUMBER:_________________

Date of Birth:____School:____________________________

Diagnosis(es):____ICD-9 code(s):_____________________

Parent/Guardian:____Phone number:____________________

Describe the Student's Disability or Medical Condition that requires the student to have a special diet and the major life activity affected by the student's disability or condition:

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____

History of anaphylaxis reaction due to severe food allergy: _____Yes _____No

If yes, please provide documentation.

History of allergy testing to indicate food allergy: _____Yes ____No

Intolerance to foods? If yes, which foods?____

List food(s) to be omitted from the diet and food(s) that may be substituted:

Omit:____

Alternatives:____

Registered Dietitian consulting with the patient:

Name:____Phone Number:_____________

Licensed Physician/Practitioner Signature:____

Phone Number:_____________________Fax Number:___________________

Print Name:____

Mailing Address:____

***Provider, please return completed and signed prescription form to School Nurse**

Copies to: LLS School Nurse Cafeteria Manager