MUKILTEO SCHOOL DISTRICT

H103

Health Services

DIET PRESCRIPTION FOR MEALS AT SCHOOL

Student's Name________________________Date of Birth_____________Age________

Name of School: _____________________________________ Grade: _____________

Section A: To be completed by the child's Physician (if describing a disability) or a recognized Medical Authority.

Does the child have a disability? □Yes □No

If Yes, describe the major life activity affected by the disability _________________________

Does the child have a non-disabling medical condition? □ Yes □No

If Yes, describe the medical condition____

Does the child have special nutritional or feeding needs? □Yes □No

If Yes, describe the specific need____

If you answered YES to any of the questions above, complete the following and return to the Lunchroom Manager at the student's school or fax to Nutrition Services at 425 710-4460.

Section B: Diet Prescription – please attach additional instructions if necessary.
(To be completed by the child's Physician or a recognized Medical Authority)

If foods are listed to be omitted from the diet then foods to substitute must also be listed.

Foods to Omit:	Foods to Substitute:
_________________________________	_________________________________
_________________________________	_________________________________
_________________________________	_________________________________

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

____ ______________________

Signature of Physician or recognized Medical Authority Date signed

____ ______________________

Printed Name Phone Fax

I understand that if my child's medical or health needs change, it is my responsibility to notify Nutrition Services and the school nurse and have a new Diet for Prescription Meals at School form completed.

____________________________ ___________________________ __________________

Parent/Guardian Signature Phone number Date signed

□ I give Nutrition Services and the School Nurse permission to speak with the above named Physician or Authorized Medical Authority to discuss the dietary needs described above.

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Parent/guardian initials and date

Original – Lunchroom Manager ____ (date) 1st Copy – Nutrition Services _____ (date)

Additional copies to ____