SFS – 59
Rev. 7/17

Food and Nutrition Services
Diocese of Lafayette
Diet Prescription for Meals at School

PLEASE PRINT

Student Name____ Age________
School ____________________________ Grade___________________
Parents Name____
Address____Phone_______________
City____________________________ State___________ Zip__________
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.

____

Diet Prescription (check all that apply)

____ Food Allergy ___PKU ____ Hypoglycemic ___ Diabetic ___Increased/Decreased Calories

Other (Description) ____

Specific Foods to Omit (Example: If Milk is to be omitted does that also include cheese and pudding)
List each food to be omitted:

____

____

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

Office Telephone____

____ ____________
Licensed Physician/Recognized Medical Authority Signature Date

Printed Physician's Name____

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