MASSENA CENTRAL SCHOOL DISTRICT SPECIAL NEEDS FORM
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of student for whom special foods at school are requested: _____

Disability or medical condition that requires the student to have a special diet. Include brief description of the **major life activity** affected by the student's disability.

_____

_____

Is this condition permanent or temporary? _____
If temporary, please give length of time instructions are to be followed with explanation:

_____

_____

Diet Prescription: (Check all that apply)

__ Diabetic (Describe) _____
__ Reduced Calorie (Describe) _____
__ Increased Calorie (Describe) _____
__ Modified Texture (Describe) _____
__ Allergies (Describe) _____
__ Other (Describe) _____

_____

Foods Omitted and Substitutions: _____

_____ Meat and Meat Alternate (nuts, beans) may substitute with: _____

_____ Bread and Cereal (grains) may substitute with: _____

_____ Milk and Milk Products (includes ice cream) may substitute with: _____

_____ Fruit and Vegetables may substitute with: _____

Other Information Regarding Diet or Feeding: (Please provide additional information on the back of this form or attach to this form.)

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.

_____ _____

Physician's Signature Office Phone Number Date

_____

Print Physician's Name

_____

Address