Children with a Life-Threatening Food Allergy
Diet Prescription for Meals at School

Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability: _____

Major life activity affected: _____

Or

Brief description of medical condition: _____

Diet prescription (check all that apply):

- ☐ Increased calorie _____ #kcal
- ☐ Decreased calorie _____ #kcal
- ☐ Diabetic
- ☐ PKU
- ☐ Food allergy
- ☐ Other_____

Texture Modification

- ☐ chopped
- ☐ ground
- ☐ pureed
- ☐ liquefied

Tube feeding

- ☐ liquefied meal
- ☐ formula _____ type_____

Foods to Omit	Foods to Substitute
_____	_____
_____	_____
_____	_____
_____	_____

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

_____ _____

Licensed Physician Signature Date Phone Number

From: *Guidelines for Care of Students with Anaphylaxis (March 2009) OSPI Publication 09-0009*