Pointe Coupee Parish School System
Child Nutrition Program

Post Office Drawer 579- 321 Napoleon Street New Roads, Louisiana 70760

Diet prescription for Meals at School
2016 - 2017
This document is in effect for the current school year and must be renewed annually.

Student's Name: _____ Age:_____ DOB:_____ Student #_____

School: _____ Grade:_____ Homeroom Teacher: _____

Parent's Name: _____ Parent's E-mail_____

Address:_____ Telephone: _____ Cell: _____
(Street or P.O. Box) City Zip

1. Does the child have a disability? **Yes or No**. If yes, describe the major life activities affected by the disability.
   _____
2. If the child is not disabled does the child have special nutritional or feeding needs? **Yes or No**
3. Does your child have an Epi-Pen for specific food or foods? **Yes or No** If yes, please list food or foods._____

Please complete section below:

Medical Condition:_____

Diet Prescription: _____

(mark all that apply):

Food Intolerance:

____ Eggs-PURE FORM ONLY
____ Milk- PURE FORM ONLY*
____ Milk and Dairy ONLY*
____ Soy- PURE FORM ONLY
____ Wheat- WHOLE/UNPROCESSED ONLY
____ Wheat (due to Celiac Disease)
____ Red Dye

Eliminate ALL foods that may contain any form of:

____ Eggs Proteins
____ Fish
____ Milk Proteins
____ Nuts
____ Peanuts
____ Shellfish
____ Soy

Other _____
_____
_____

Texture Modification Required:

_____ Level 1: Dysphagia Pureed diet. All foods will have a "SOFT" mashed potato/pudding like consistency.
_____ Level 2: Dysphagia Mechanically Altered. Foods are moist, soft-textured, and easily formed into a bolus.
_____ Level 3: Dysphagia Advanced. Nearly regular textures with the exception of very hard, sticky, or crunchy foods.

*__Please note if juice or water may be served__
__In place of milk Yes_____ No_______

**__Is milk eliminated due to milk allergy _____or Lactose intolerance_____?__

**__Diabetic Diets "Carbohydrate Distribution" = Breakfast_____Lunch_____Snack_____(# of Carbs/meal)__

Any Other Specific Dietary Need:_____

Specific Foods to Omit: _____ Specific Foods to Substitute: _____

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

Office Address: _____ Office Telephone:_____
_____ Office Fax: _____

_____ Date_____
Licensed Physician /Recognized Medical Authority Signature

Guidelines and Requirements for Diet Prescription

These guidelines and requirements have been established to ensure the safety of students when medically necessary menu changes must be implemented.

- A new Diet Prescription Form **MUST** be completed every school year.
- Only the current school year Diet Prescription Form will be accepted.
- All sections **MUST** be fully complete.
- **Diet prescription form MUST be signed by Physician/recognized Medical Authority**.
- Diet Prescription forms will not be altered unless the Diet Prescription Form is updated by the **physician.**
- Diabetic Meal Plans: please provide the number of carbohydrates for each meal and snack.
- Food Allergens: please provide specific information regarding foods to omit and substitute.
- Texture Modification: please provide specific level of dysphagia diet acceptable to ensure proper texture modification procedures.
- If the student cannot have fluid milk, please document appropriate substitute.
- Diet restrictions due to religious beliefs- parent/guardian **MUST** complete the current year Diet Prescription Form stating the specific food to eliminate along with reason.
- Diet Prescription Forms **MUST** be completed before implemented at school site.

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