Sultan School District
Diet Prescription for Meals at School

Student Name____Age__________

School____Grade________

Disability____

OR Non-Disabling Medical Condition_______________________________________

Physician Requested Diet Prescription
(check all that apply)

___Increased calorie_________#kcal
___Decreased calorie_________#kcal
___Diabetic
___PKU
___Food allergy
___Food intolerance
___Other_______________________
____

Texture Modification:
___chopped
___ground
___pureed
___liquefied

Tube Feeding:
___liquefied meal
___formula______________________

Foods to Omit:

____
____
____
____

Foods to Substitute:

____
____
____
____

I certify the above-named student needs special school meals prepared as described above because of his/her disability or non-disabling medical condition.

____ ____________________________
Licensed Physician or Medical Authority Signature Date Phone Number

____ ____________________________
Parent/Guardian Signature Date Phone Number

Cc: Food Services, School Kitchen, School Nurse