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Miami-Dade County Public Schools
giving our students the world

Department of Food and Nutrition

Diet Prescription for Meals at School

Part I (to be filled out by parent or guardian)

Name of Student: _____ Date of Birth: _____ Age: _____
(Last) *(First)* *(MI)*

School: _____

Name of Parent/Guardian(s): _____

Parent/Guardian(s) Daytime Phone No.: _____ _____ _____
Parent/Guardian's Signature

Part II (to be filled out by the physician)

Name of Student _____ requires special meals at school.

Patient´s diagnosis: _____

Brief description of patient´s condition related to the meal for diet modification: _____

_____

_____

_____

Diet Prescription (check all that apply)

☐ Texture Modification:
- ☐ Pureed
- ☐ Ground
- ☐ Chopped
- ☐ Regular
- ☐ Thickened Liquids
- ☐ Other (describe) _____

☐ Nutrient Modification:
- ☐ Increase Calories
  Description: _____
  _____

☐ Decease Calories
  Description: _____
  _____

☐ Nutrient Restriction
  Description: _____
  _____

Foods Omitted and Substitutions (please check specific foods to be omitted and suggest substitution).

☐ Nuts ☐ Milk ☐ Wheat ☐ Peanuts ☐ Fish ☐ Mollusks
☐ Eggs ☐ Soybean ☐ Cheese ☐ Chicken ☐ Shellfish ☐ Other: _____

Specific Food Substitution: _____

_____

_____

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

Physician´s Name (please print)	Physician´s Signature	Office Phone No.	Date

This form is valid for up to one year from evaluation date, but may be updated as determined by the physician.

Original - Food Service Manger's Site
Yellow - School Office Site
Pink - Physician's Copy

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