

Methow Valley School District Diet Prescription for Meals at School

Student's Name: _____ Date of Birth: _____ Age: _____

Name of School: _____ Grade: _____

Physician or a recognized Medical Authority to complete

Section A:

Does the child have a disability? **No** **Yes**, describe the major life activity affected:

Does the child have a non-disabling medical condition? **No** **Yes**, describe the medical condition:

Does the child have special nutritional or feeding needs? **No** **Yes**, describe the specific need:

If you answered YES to any of the questions above, complete the following and return to the School office.

Section B: Diet Prescription- please attach additional instructions if necessary.

If foods are listed to be omitted from the diet, foods to substitute **must** be provided.

Foods to Omit:

Foods to Substitute:

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

Physician or Recognized Medical Authority Signature

Date signed

Name: _____ Office Phone: _____ Fax: _____
Type or Print

Parents/guardians to complete:

I understand that if my child's medical or healthy needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed.

Parent/Guardian's Signature

Home Phone

Date signed

I give the school nurse permission to speak with the above named Physician or Authorized Medical Authority to discuss the dietary needs described above.

(parent/guardian's initials and date)