

OSPI School Meal Programs

Dietary Prescription for Student WITHOUT Disability

IS THIS REQUEST FOR COWS MILK SUBSTITUTION (check box): Yes No

FOR INTERNAL INFORMATION ONLY: If yes, the local education agency must request approval from the Office of Superintendent of Public Instruction - Child Nutrition Services prior to making milk substitutions and must follow USDA regulations. Requests for milk substitutions may be signed by a parent/guardian OR recognized medical authority for students without disabilities.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name Birth Date Age Grade School

Parent/Guardian Name Phone

Mailing Address City/State/Zip

Signature of Parent/Guardian Date

DIET ORDER - RECOGNIZED MEDICAL AUTHORITY* MUST COMPLETE and SIGN THIS SECTION.

*Recognized Medical Authority: State licensed health care professional authorized to write medical prescriptions under State law

1. What is the student's special dietary need?
2. List all food(s) to be omitted:
3. List all food(s) to be substituted:
4. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):
5. Describe any other comments about the student's eating or feeding patterns:

Signature of Recognized Medical Authority Date E-mail Phone

Printed Name of Recognized Medical Authority Address

OSPI School Meal Programs

Dietary Prescription for Student WITH Disability

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name

Birth Date

Age

Grade

School

Parent/Guardian Name

Phone

Mailing Address

City/State/Zip

Signature of Parent/Guardian

Date

DIET ORDER – RECOGNIZED MEDICAL AUTHORITY* MUST COMPLETE and SIGN THIS SECTION.

*Recognized Medical Authority: State licensed health care professional authorized to write medical prescriptions under State law

1. List student's disability: _____
(Include life-threatening allergies which cause an immune system response to a particular food/ingredient/additive.)

2. What is the major life activity(s) affected?

3. Describe how the disability restricts student's diet:

4. List all food(s) and/or milk to be omitted:

5. List all food(s) and/or milk to be substituted:

6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

7. Describe any other comments about the student's eating or feeding patterns:

Signature of Recognized Medical Authority

Date

E-mail

Phone

Printed Name of Recognized Medical Authority

Address