PARENT/GUARDIAN INFORMATION LETTER
"DIET PRESCRIPTION FOR MEALS AT SCHOOL" FORM

Due to the USDA (United States Department of Agriculture) regulations, Jefferson County Board of Education **cannot replace or make any diet substitutions** unless we have a "Diet Prescription for Meals at School" form completed by your Licensed Physician/Recognized Medical Authority. This includes, but is not limited to, making substitutions for milk intolerances. **A licensed physician is required to fill out the "Diet Prescription for Meals at School" form if the allergy is life-threatening.** Any recognized medical authority may fill out the form for all other food allergies or intolerances. **Each form is valid only for the current school year.**

TO PROCESS THE FORM PLEASE FOLLOW THESE STEPS

- Please review the "Diet Prescription for Meals at School" form
- Give the form to your Licensed Physician/Recognized Medical Authority to complete
- Return the completed form to the School Nurse

Understand that if your child's medical or health needs change at any time, it is your responsibility to notify the School Nurse **and complete a new "Diet Prescription For Meals at School" form with your Licensed Physician/Recognized Medical Authority.** Again, each form is only valid for the current school year.

Definition of Recognized Medical Authority

In Alabama, a recognized medical authority is defined as one of the following health professionals: doctor (licensed physician), physician assistant, nurse practitioner, registered nurse and registered dietitian.

Revised February 2009

Diet Prescription for Meals at School Form

FOR SCHOOL NURSE:
Name of student: _____ D.O.B._____ ID# _____
School: _____ Grade: _____ Teacher: _____

NOTE TO PARENTS/GUARDIANS: **The district requires that all students who need a special meal for Breakfast or Lunch must do the following:**
l. Present this form signed by parent or legal guardian and by prescribing physician/recognized medical authority (U.S. only).
2. Keep the diet prescription current by submitting a new form at the beginning of each school year.
3. To change a diet order, please complete and return a new form signed by a parent or legal guardian and by the physician/recognized medical authority.

FOR PHYSICIAN/RECOGNIZED MEDICAL AUTHORITY:
Breakfast Meal Needed: (Circle one) YES or NO Lunch Meal Needed: (Circle one) YES or NO
List Medical Conditions or diagnoses for special diet:
_____

Therapeutic Diet Prescription: (Check all that apply)
_____Diabetic: (Type l _____ Calories**;** Type2 _____ Calories) _____Increased calories
_____Reduced Calories (low fat, low cholesterol, low simple carbohydrate) ____High Fiber _____Peptic Ulcer Disease
_____Lactose Intolerance _____ Food Allergies: (specify_____)
_____ Other: (Specify: _____)
HT: _____ WT: _____ BMI (if available): _____
Mechanically Altered. Denote texture allowed:
____Soft ____Chopped ____Ground ____Pureed
Other information/instructions regarding the Diet or Feeding:

_____

_____

Is parent allowed to discontinue diet order without written physician consent? YES or NO
If Yes, parent must notify the Child Nutrition Program in writing with the intent to discontinue.
Diet Expiration Date: _____

_____	_____	_____
Printed Name of Physician/Recognized Medical Authority	**Signature of Physician/Recognized Medical Authority**	**Date**

Address: _____ **Phone #** _____ **Fax#**_____

FOR PARENTS/GUARDIANS
By signing below, I _____, parent of _____authorize the Child
PRINT NAME **PRINT NAME**
Nutrition Program personnel to serve my child the diet recommended by the physician/recognized medical authority.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Home Phone#	Emergency Phone#

Original – Lunchroom Manager _____ 1st Copy – Nutrition Services _____
Date Date

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