ACADIANA CHRISTIAN SCHOOL/CHILD NUTRITION PROGRAM
DIET PRESCRIPTION FOR MEALS AT SCHOOL
TO BE COMPLETED BY A LICENSED PRESCRIBER

Student's Name_____________________________________ Age:___________ Grade:____________

Address:____ Telephone:(_____)___________________
(Street, City, State, Zip Code)

List disability/medical conditions that require special dietary modifications:

____

____

DIET PRESCRIPTION: (Check or complete all that apply)

Diabetic:

Carb Counting(gms):______Breakfast ______AM Snack _____Lunch _____PM Snack

Texture Modification:

_____Chopped(circle) Fine or Bite Size ______Ground _______Pureed _____Liquefied

Fluid Consistency:

Specify:__________________________________

_______ Hypoglycemic _______No Concentrated Sweets ________Increased kcal_____#kcal

Decreased kcal_______#kcal

OTHER:____

Tube Feeding: Formula/Rate/Schedule____

FOOD INTOLERANCE:

Level I- Eliminate intolerable food only

___Milk(fluid form)--cheese/yogurt allowed

Substitute:___Juice ____Water

___Milk and Dairy Products(no cheese/yogurt)

___Eggs

___Wheat(breaded products OK)___Soy

___Allowed to have products w/<2% soy content

FOOD ALLERGY:

Level II- Eliminate products w. food allergen

___Milk ___Eggs ____Fish(fin)

___Shellfish ___Tree Nuts ___Peanuts

___Wheat ____Soy

Other______________________________

Specific food that can be substituted: (list)

____

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

Date:___________________

Office Address and Phone Number:____

Licensed Physician/Nurse Practitioner/ Physician's Assistant Signature:_______________________________