Form A: Dietary Prescription for **Student WITH Disability**

OSPI Child Nutrition Programs

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	Student Number

DIET ORDER – LICENSED PHYSICIAN MUST COMPLETE and SIGN THIS SECTION.

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 <u>omitted</u>:

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

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 Licensed Physician	Date	E-mail	Phone

Printed Name of Licensed Physician	Address