

DIOCESE OF ALEXANDRIA
CHILD NUTRITION PROGRAM
DIET PRESCRIPTION FOR MEALS AT SCHOOL
 Return completed form to cafeteria manager

Patient Information

Student's Name _____ Age _____
 School _____ Grade _____
 Parent's Name _____
 Mailing Address _____
 City _____ State _____
 Telephone (____) _____

Disability

Does the student have a disability that requires a special diet? Yes _____ No _____
 If yes, describe the major life activities affected by the disability. _____
 (See attached *Bulletin 1196 Section 727* for further information.)

Medical Condition

If the student is not disabled, check the medical condition that requires special nutritional or feeding needs.
 (Check all that apply):

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Increased Calorie _____ #kcal |
| <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Reduced Calorie _____ #kcal |
| <input type="checkbox"/> Hypoglycemic | <input type="checkbox"/> Texture Modification |
| | Chopped _____ Ground _____ |
| <input type="checkbox"/> PKU | Pureed _____ Liquefied _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Tube Feeding |
| | Liquefied Meal _____ Formula _____ |

Foods To Be Omitted and Substitutions

Check the food groups to be omitted. Identify specific foods to omit and list foods to be substituted. If necessary, attach additional information or instructions regarding the diet or feeding.

- | | | |
|----------------------|---|--|
| Food Groups to Omit: | <input type="checkbox"/> Meat and Meat Alternatives | <input type="checkbox"/> Milk and Milk Products |
| | <input type="checkbox"/> Fruits and Vegetables | <input type="checkbox"/> Bread and Cereal Products |

Specific Foods to Omit

Specific Foods to Substitute

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.

 Office Address

(____) _____
 Office Telephone #

 Licensed Physician/Recognized Medical Authority Signature

 Date

*Signature of Licensed Physician required if student is disabled.

DIOCESE OF ALEXANDRIA

**Allergy/Food
Restrictions Form**

Student's Name _____ Age _____

School _____ Grade/Classroom _____

Parent's Name _____

Address _____ Telephone (____) _____
(Street or P. O. Box)

City _____ State _____

Does the student have a disability that requires a special diet modification? Yes _____ No _____

Diet Prescription (Check all that apply):

- Diabetic
- Food Allergy
- Hypoglycemic
- Other _____

Foods Omitted and Substitutions: Please identify specific foods to omit and list foods to be substituted. (i.e. Omit milk and substitute juice)

Specific Foods to Omit	Specific Foods to Substitute
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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.

Office Address _____ Office Telephone# (____) _____

Licensed Physician/Recognized Medical Authority Signature

Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-3333. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.asc.usda.gov/complaint_filing_cust.html, and of any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-6992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 696-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.