BOYLE COUNTY SCHOOLS
SCHOOL HEALTH DEPARTMENT

BOYLE COUNTY SPECIAL DIET PRESCRIPTION FORM

Please have this form completed and signed by a licensed Health Care Provider for a child with a disability or life threatening food allergy in order for a student to receive modifications or substitutions to the regular school meals. Return completed and signed form to your child's School Nurse.

Date: _____

Student Name: _____ Date of Birth: _____

School: _____ Diagnosis(es): _____

Describe the student's ___Disability or ___ Medical Condition that requires the student to have a special diet and the major life activity affected by the student's disability or medical condition:
_____
_____
_____

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".
Foods: _____
Texture change: ___cut up or chopped into bite-size pieces ___ finely ground ___pureed

List any special equipment or utensils that are needed: _____

History of anaphylaxis reaction due to severe food allergy: ___ Yes ___No

History of allergy testing to indicate food allergy: ___ Yes ___No

Intolerance to foods? If yes, which foods? _____

List food(s) to be omitted from the diet and food(s) that may be substituted:
Omit: _____
Alternatives: _____

Licensed Provider: _____ (Signature) Date: _____

Phone Number: _____

Parent Name (print): _____ Phone Number: _____
Mailing Address: _____