Logansport Community School Corporation

DIET PRESCRIPTION FORM

School Year: _____

*__Indicates required field/must be completed.__

*Student's Name:_____DOB:_____

*School:_____GRADE:_____

*Parent/Guardian Name: _____

*Phone:_____ Email:_____

I give Health Services/Nursing/Nutrition Services permission to speak with the Health Care Provider below to discuss my child's special dietary needs.

_____

Parent/Guardian's Signature Date

*Diet Prescription (check one or more):

☐ **Diabetic** ☐**Calorie-Controlled** ☐**Other (describe):_____**

Texture Modification: ☐**Chopped** ☐ **Ground** ☐**Pureed**

☐ **Food Allergy (specify all):_____**

[ ] Non-disabling (food sensitivity)

[ ] Disabling Allergy (includes severe and/or anaphylaxis)

*Major life activity affected by the student's **disability** (check one or more) do **not** check for sensitivity's:

☐ Caring for Self ☐ Hearing ☐ Learning
☐ Performing Manual Tasks ☐ Speaking ☐ Performing Manual Tasks
☐ Walking ☐ Breathing ☐ Other:_____
☐ Seeing ☐ Eating

*Omitted Foods/Beverages	*Allowed Substitution(s)

Additional Orders/Recommendations (i.e. peanut-free lunch table, etc.):

_____

_____

*I certify that the above named student needs special meals prepared as described above because of the student's condition.

_____ _____ _____ _____

Physician's Signature Physician's Printed Name Office Phone Number Date

PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE or fax to (574) 722-2940.
Questions? Contact Food Service Department at (574) 722-2911
An updated form must be provided every school year and for any changes in child's dietary needs.