St. Tammany Parish School Board

Please return to the school.
For the safety of the student, this form MUST be thoroughly legibly completed.

PRESCRIPTION FOR SCHOOL MEAL MODIFICATION

Student's Name: _____ Age: _____

School: _____ Grade/Classroom:_____

Parent's Name: _____ Parent's E-mail:_____

Address: _____ Telephone: _____
(Street or P.O. Box) City Zip

List the Medical Condition that requires special nutritional or feeding needs:

_____

Diet Prescription (mark all that apply)

Food Intolerance:

☐Eggs – pure form only
☐ Milk-beverage form only*
*Substitute (please circle) Juice or Water
☐ Milk AND Dairy only*
* Substitute (please circle) Juice or Water
☐ Soy- pure form only
☐ Wheat-whole or unprocessed only
☐ Other

Eliminate ALL foods that may contain any form of:

☐ Eggs Proteins
☐ Fish
☐ Milk Proteins
☐ Nuts
☐ Peanuts
☐ Shellfish
☐ Soy
☐ Wheat
☐ Other

Consistency Only:

☐ Puree'
☐ Mechanical Soft
☐ Chopped

Any Other Specific Dietary Need:_____

***Please note if juice or water may be substituted for liquid milk. If juice or water substitute is not noted on diet prescription form, student will be charged for juice or water.**

Specific Foods to Omit

_____
_____
_____

Specific Foods to Substitute

_____
_____
_____

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

Office Address: _____
_____

Office Telephone: _____
Office Fax: _____

_____ _____
Licensed Physician/Recognized Medical Authority Signature Date