

BELLINGHAM SCHOOL DISTRICT
Diet Prescription for Meals at School - Nutrition Services

Parent Instructions:

1. *If your child needs a special Diet Prescription for SCHOOL MEALS due to a health condition requiring a special diet, complete this form.*
2. *The Diet Prescription should be completed and signed by a Physician or Recognized Medical Authority.*
3. *Return the completed form to the school secretary.*

School Secretary:

1. *Make three copies of the Diet Prescription; one for the School Nurse, one for the Food Service Lead, and one for the office.*
2. *Send the original to the Food Services Department at Central Services, Attention: Food Service Manager.*

Student name: _____

Birthdate: _____

School: _____

Grade: _____

To be completed by the child's Physician (if describing a disability) or a recognized Medical Authority

Section A: Health condition requiring a special diet:

Food allergy

Has a life threatening /severe reaction to: _____

Has a mild reaction and needs to avoid: _____

Other: _____

Section B: Diet Prescription -Enter below additional instructions if necessary.

Foods to Omit:

Foods to Substitute:

I certify that the above named student needs special school meals prepared or served as described above because of the student's disability or chronic medical condition.

Physician or Recognized Medical Authority Signature

Date signed

Name: _____ Office Phone: _____ Fax: _____

Type or Print

I understand that if my child's medical or health needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed.

Parent/Guardian's Signature

Home Phone Number

Date signed

Original – Food Services (Roeder) Computer Entry _____

Copy: Food Service Lead _____

Date

Copy: School Secretary _____

Nurse Notified: _____