SPECIAL MEALS PRESCRIPTION FORM

Local School District/Name of Institution:

Street Address:

City: ,NH Zip Code:

Student Name: DOB:

SASID: School Name/Institution: (if different than above)

Disability: [choose one] Disabled (Federal Policy: as determined by physician), Non-disabled (school district policy)

Disability or medical condition: [choose one] Description of Condition Requiring Special Diet:

Special Diet: check all that apply. ☐ Diabetic ☐ Reduced Calorie ☐ Increased Calorie ☐ Modified Texture ☐ Other:

Date Effective: From: To:

Meats/Protein Foods

Can't Have: [choose one] [choose one] [choose one] If other specify:

Food Prep: [choose one] Apply this preparation to all Meat/Protein Foods: [choose one]

Vegetables/Fruit

Can't Have: [choose one] [choose one] [choose one] If other specify:

Food Prep: [choose one] Apply this preparation to all Fruits/Vegetables: [choose one]

Grains/Breads/Cereals

Can't Have: [choose one] [choose one] [choose one] If other specify:

Food Prep: [choose one] Apply this preparation to all Breads/Grains/Cereals: [choose one]

Milk/Dairy Products

Can't Have: [choose one] [choose one] [choose one] If other specify:

Food Prep: [choose one] Apply this preparation to all Milk/Dairy Products: [choose one]

Fats/Sauces

Can't Have: [choose one] [choose one] [choose one] If other specify:

Combination Foods:

Can't Have: [choose one] [choose one] [choose one] If other specify:

Food Prep: [choose one] Apply this preparation to all Combination Foods: [choose one]

Liquids

Tube Feeding: [choose one]

If yes, specify formula:

Liquids By Mouth Allowed: [choose one]

Select Type of Thickened Liquids Needed * : [choose one]

Select Thickeners: [choose one]

*Nectar= thicken enough to coat a spoon, Honey = thicken enough to stand a straw straight in a cup

Thickening Directions:

SAFE EATING PLAN

To be completed by Special Education Team or 504 Coordinator

Describe any special positioning needed while eating/drinking:

Describe any special utensils or feeding equipment needed:

Describe any special methods for presenting food/drink:

Provide safe eating environment by:

- ☐ Peanut Free Table
- ☐ Quiet Table/Area
- ☐ Other:

Liquids served, check all that apply:

☐ bottle ☐ sippy cup ☐ with straw

☐ juice box holder ☐ open cup ☐ spoon ☐ Other:

PHYSICIAN/MEDICAL AUTHORITY SIGNATURE SECTION

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

☐ I certify that the above named student would benefit from special meals as described above, however this child is not disabled. It is up to the discretion of each school/institution if and for what conditions they will provide substitutions.

_____

Physician's/Medical Authority's Signature

Office Phone Number

Date

Physician's/Medical Authority's Printed Name

PARENT/GUARDIAN SECTION

☐ YES Parent/Guardian accepts accommodations offered and his/her child will be participating in the Child Nutrition Program or any other program offered within the child's instituion.

☐ NO Parent/Guardian declines accommodations offered and his/her child will not be participating in the Child Nutrition Program or any other program offered within the child's institition.

_____

Parent's/Guardian's Signature

Date

cc:

☐ Parent/Guardian ☐ Physician ☐ Nutritionist ☐ Feeding and Swallowing Specialist

☐ Food Service Director ☐ School Nurse ☐ School Principal ☐ Special Ed Coordinator

For Official Use: Date returned to the Special Ed coordinator at the District Office:

Date