**FORM 837 – Revised 10-21-14**
SFS — 59
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# Food and Nutrition Services
# Diocese of Lafayette

## Diet Prescription for Meals at School

**PLEASE PRINT**

Student Name _____ Age _____

School _____ Student ID Number _____

Parents Name _____

Address _____ Phone _____

Does the student have a disability that requires a special diet? Yes ____ No ____
If Yes, describe the major life activities affected by the disability.

_____

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

## Diet Prescription (check all that apply)

_____ Food Allergy _____ PKU _____ Hypoglycemic _____ Diabetic

Other (Description) _____

**Specific Foods to Omit** ( Example: if Milk is to be omitted does that also include cheese and pudding) List each food to be omitted:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

Office Address _____

Office Telephone _____

_____ _____
Licensed Physician/Recognized Medical Authority Signature Date

Printed Authority's Name _____

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