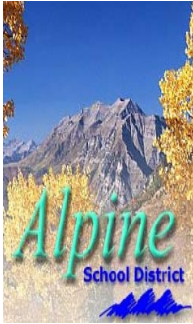


SPECIAL DIET PRESCRIPTION for MEALS in ALPINE SCHOOL DISTRICT



Student's Name: _____
 Student's Age: _____ Student's Grade: _____
 Student's School: _____
 Student's Disability: _____
 Major Life Activity affected: _____
 Non-disabling Medical Condition: _____

DIET PRESCRIPTION [check all that apply]

<input type="checkbox"/>	<i>Increased Calorie</i> _____ #kcal	<input type="checkbox"/>	TEXTURE MODIFICATION
<input type="checkbox"/>	<i>Decreased calorie</i> _____ #kcal	<input type="checkbox"/>	<i>Chopped</i>
<input type="checkbox"/>	<i>Diabetic</i>	<input type="checkbox"/>	<i>Ground</i>
<input type="checkbox"/>	<i>PKU</i>	<input type="checkbox"/>	<i>Pureed</i>
<input type="checkbox"/>	<i>Food Allergy</i>	<input type="checkbox"/>	<i>Liquified</i>
		<input type="checkbox"/>	<i>Tube Feeding</i>
		<input type="checkbox"/>	<i>Liquified Meal</i>
		<input type="checkbox"/>	<i>Formula _____ type</i>

Foods to Omit:

Foods to Substitute

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

 Signature of Physician

 Date

 Office Telephone Number of Physician