LAFAYETTE PARISH SCHOOL SYSTEM
CHILD NUTRITION SERVICES
101 Evans Lane
Lafayette, LA 70506
337-521-7370

DIET PRESCRIPTION FOR MEALS AT SCHOOL
2021-2022

This document is in effect for the current school year and must be renewed annually.

Student's Name: __________________________ Date of Birth: __________________
School: __________________________________ Grade: _______________________
Parent/Guardian Name: ______________________ Phone: _____________________
Address: ____
List Disability/Medical Condition(s) that require special dietary needs:
____

PART A -

DIET PRESCRIPTION (check all that apply):

- ◻ **Diabetic: _______** Carbohydrate counting OR *Carbohydrate Grams:*
  - ______ Breakfast
  - ______ Snack _____AM
  - ______ Lunch
  - ______ Snack _____PM
- ◻ **Lactose Intolerance (eliminate fluid milk):**
  Other dairy is allowed: cooked cheese, etc. ______ Yes _____ No
  Please document substitute for Fluid Milk: ______ Juice _____ Water
- ◻ **Calorie Count:**_____Breakfast Calories _____Lunch calories ____am/pm Snack Calories
- ◻ **Texture Modification:** ____Diced _____ Chopped ____ Ground
  ____ Puree (check one): ___ Milk-like ___ Nectar-like ___ Honey-like ___ Pudding-like
- ◻ **Other Diet Prescription:** ____
- ◻ **Religious Reason:** ____

FOOD INTOLERANCE:
(digestive system response)
Level I-eliminate intolerable food only

- ◻ Milk (fluid form only) – cheese allowed
  -Substitute: ___ juice ___ water
- ◻ Milk and Dairy Products
- ◻ Eggs
- ◻ Wheat
- ◻ Soy
- ◻ Other: _________

FOOD ALLERGY:
(immune system response)
Level II-eliminate products with food allergen

- ◻ Milk
- ◻ Eggs ___ history of inhalation reaction
- ◻ Fish ___history of inhalation reaction
- ◻ Shellfish ___history of inhalation reaction
- ◻ Tree Nuts ___history of inhalation reaction
- ◻ Peanuts ___history of inhalation reaction
- ◻ Wheat
- ◻ Soy
- ◻ Other: ______________________

PART B -

◻ Special Diet Status changed, student no longer needs special diet

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

____ ______________
Signature of Physician/Medical Authority/ Print name **Date**

Office Address: ____________________ ______________ ________ ________
Street or P.O. Box City State Zip Code
Office Phone: ______________________ **Office Fax:** ______________________

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Guidelines for Diet Prescription for Meals at School

These guidelines and requirements have been established to ensure the safety of students when a medically necessary menu change must be implemented.

- Please submit a current Diet Prescription Form each year to ensure that we have the most up to date information on your child (Example: please use DIET PRESCRIPTION FOR MEALS AT SCHOOL 2021-2022).
- Please complete all sections, including student's name, school, date of birth, parent's name, address, and telephone number.
- Choose and complete the area that applies to the student: diabetic, calorie count, texture modification, other diet prescription, food intolerance, or food allergy.
- Diabetic meal plans: List the carbohydrate grams (45 grams, 60 grams, etc.) required for breakfast, lunch, and snacks.
  Carbohydrate counts of the menu are provided on a weekly basis.
- If the student requires a specific number of calories, please list the caloric amount for breakfast, lunch, and snacks.
- If the student requires a texture modification, indicate the necessary consistency.
- Diet restrictions due to religious beliefs are acknowledged by completing a current diet prescription and indicating “Religious Reason”.
  - Diet restrictions due to religious beliefs can be signed by the student's **parent or guardian.**
- If the student has a **Food Intolerance (digestive system response) - Level 1**, check foods that apply.
  - The indicated intolerable foods will be eliminated from the student's meal tray in its whole form (example: the student has an intolerance to eggs, the student will not be served whole eggs such as scrambled eggs, hard boiled eggs, etc.)
- If the student has a **Food Allergy (immune system response) - Level II,** check the foods that apply.
  - The indicated allergen foods will be eliminated from the student's meal tray in its whole form as well as any food that contains the allergen food as an ingredient. (Example: the student has an allergy to eggs; the ingredient listing will be reviewed for eggs and any foods containing eggs will be eliminated from the student's meal).
  - Please Indicate if the student has a history of an inhalation induced anaphylaxis reaction to the specified allergen.
- The Diet Prescription, Food Intolerance, and Food Allergy sections must be completed and signed by a Physician or a recognized medical authority.
- Menu substitutions will be provided at the discretion of the Child Nutrition Services Office according to current food availability.

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.
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