

Taholah School District #077
P.O. Box 249
Taholah, WA. 98587
(360) 276-4780

Diet Prescription for Meals at School

Student's Name: _____ Age: _____
School: _____ Grade: _____
Disability: _____
Major life ability affected: _____
Or
Brief description of medical condition: _____

Diet prescription (check all that apply)

___ Increased Calorie
_____ # kcal
___ Decreased Calorie
_____ #kcal
___ Diabetic
___ Type 1 ___ Type 2
___ PKU
___ Food Allergy _____
___ Gluten Free _____
___ Lactose Free _____
___ Other _____

Texture Modification
___ Chopped
___ Ground
___ Pureed
___ Liquified-Tube Feeding
___ Liquified Meal
___ Formula _____ Type _____

Foods to Omit

Foods to Substitute

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

Licensed Physician Signature

Date

Phone Number