Natchitoches Parish School Board
Child Nutrition Program

JESSE DALE SKINNER
Superintendent

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DEBRA BESANT
Child Nutrition District Manager

DIET PRESCRIPTION FOR MEALS AT SCHOOL
2019-2020

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_____
Street or P.O. Box City State Zip Code

List disability/medical conditions that require special dietary needs _____

DIET PRESCRIPTION (check all that apply):

		Carbohydrate Grams	*Carbohydrate Grams*
Diabetic:	Carbohydrate Counting OR	_____Breakfast	_____AM Snack
		_____Lunch	_____PM Snack

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: ___ ___Chopped _____Ground
_____Puree (check one) Milk-like Nectar-like Honey-like Pudding-like
Other Diet Prescription:_____

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	history of inhalation reaction
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	history of inhalation reaction
Soy	history of inhalation reaction

Other:_____

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 **Date**
Office Address _____
Street or P.O. Box City State Zip Code

Office Phone_____ Office Fax_____

For NPSB Staff Only

Initial upon receipt: _____Nursing/Date_____ CNS Staff/Date _____ Mgr Date

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 2016-2017)
- Please complete all sections, including student's name, school, date of birth, parent's name, address, and telephone number.
- The Diet Prescription, Food Intolerance, and Food Allergy sections must be completed and signed by a Physician or a recognized medical authority.
- 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 amount of calories, please list the caloric amount for breakfast, lunch, and snacks.
- If the student requires a texture modification, indicate the necessary consistency.
- If the student has a **Food Intolerance (digestive system response) – Level I**, check the 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 tray).
  - Please indicate if the student has a history of an inhalation induced anaphylaxis reaction to the specified allergen.
- Diet restrictions due to religious beliefs are acknowledged by completing a current diet prescription and indicating "Other diet Prescription." Please indicate reason (example: due to religious beliefs).
- Menu substitutions will be provided at the discretion of the Child Nutrition Services Office according to current food availability.