LAFAYETTE PARISH SCHOOL SYSTEM
CHILD NUTRITION SERVICES

101 Evans Lane
Lafayette, LA 70506
337-521-7370

DIET PRESCRIPTION FOR MEALS AT SCHOOL
2015-2016

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 LPSS Staff Only

Initial upon receipt: __________Nursing/Date__________CNS Staff/Date __________RD/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 2015-2016)

- 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.

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