Los Lunas Schools
Special Diet Prescription Form

Please have this form completed and signed by a licensed physician for a child with a disability or a medical/dietary need in order for a student to receive modifications or substitutions to the regular school meals.

Date: _____

Student Name: _____ Student Number: _____

Date of Birth: _____ School: _____

Diagnosis (es): _____ ICD-9 code(s): _____

Parent/guardian: _____ Phone number: _____

Describe the Student's □ **Disability** □ **Medical Condition** that requires the student to have a special diet and the major life activity affected by the student's disability or condition:

_____

_____

History of anaphylaxis reaction due to severe food allergy: □ Yes □ No
If yes, please provide documentation

History of allergy testing to indicate food allergy: □ Yes □ No

Intolerance to foods? If yes, which foods? _____

List food(s) to be omitted from the diet and food(s) that may be substituted:

Omit: _____

Alternatives: _____

Registered Dietitian consulting with the patient:
Name: _____ Phone Number: _____

Licensed Physician/Practitioner: _____ *Signature*
Phone Number: _____ FAX number _____

Licensed Physician/Practitioner: _____ Print Name
Mailing Address: _____

Provider, please return completed and signed prescription form to the School Nurse

Copies to: LLS School Nurse, School Cafeteria Manager

Revised 6/20/13