ZACHARY COMMUNITY SCHOOLS
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Student Name:		DOB:
Name of School:	Grade:	Teacher:
Parent:	Phone Number:	

Diagnosis or condition which restricts diet:

Food Allergy:	**Food Restrictions:**
□ Nuts	□ Peanuts Only □ Tree Nuts Only □ All Nuts
□ Seafood	□ Fish □ Shellfish □ All Seafood
□ Milk/Dairy	□ No Fluid Milk (only fluid milk restricted) □ Cheese/Milk is the main ingredient in baked foods (Pizza, Mac-N-Cheese) □ Uncooked Milk Products (yogurt, cheese, ice cream, etc.) □ Foods made with milk, such as baked goods, butter, etc. □ Other: _____ □ Milk Substitution: □ Water or □ Other: _____ (Parents must provide special Milk Substitution)
□ Egg	□ Whole eggs (scrambled & hard-cooked) □ Eggs in baked goods (bread, cookies, cakes) □ Mayonnaise or creamy salad dressing
□ Wheat:	□ Wheat (bread, pizza crusts, pasta, crackers, etc.) □ Gluten □ Rye, Oat, or Barley (Gluten-free) □ Other: _____
□ Soy:	□ Whole Soy (Tofu, Soy milk, soy sauce) □All Soy Products (includes denatured soy. i.e., processed meats, baked goods, trace soy) □ Other:_____
□ Food Intolerance	□ Avoidance only OR □ Substitute with: _____ □ Other:_____
□Modifications Required	Liquids: □ Thin □ Nectar □ Honey □ Pudding Solids: □ Mechanical □ Soft-Chopped □ Mechanical □ Soft-Ground □ Pureed Tube Feeding**:** □ Formula: _____CC □ Water Flush: _____CC □ Other:

Print Physician's Name:	**Phone Number:**	**Date:**
Physician's Signature:	**Fax Number:**	

Return the completed form to the school nurse.