BROOME•TIOGA boces
Enriching Lives Through Education

2010-2011 DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of Student: _____ **School:** _____ **Grade**_____

Disability or Medical Condition:

Metabolic Diseases

☐ Celiac Disease (Gluten Allergy) ☐ Diabetes (circle one: type I or type II)

☐ Other: _____

Food Allergies

☐ Egg ☐ Fish ☐ Peanut ☐ Shellfish ☐ Tree Nut ☐ Soy ☐ Wheat

☐ Milk ☐ Lactose Intolerance ☐ Other: _____

Is this condition permanent or temporary? ☐ Permanent ☐ Temporary

If temporary, please give length of time instructions are to be followed with explanation:

_____

_____

Diet Prescription: (Check all that apply)

__ Celiac Disease (Describe) _____

__ Diabetes (Describe) _____

__ Allergies (Describe) _____

__ Other (Describe) _____

Foods Omitted: _____

Substitutions: ☐ Specified Substitutions: _____
☐ Substitutions as per BOCES Registered Dietitian

Other Information Regarding Diet or Feeding: (Please provide additional information on the back of this form or attach to this form.)

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

_____

Physician's Signature Office Phone Number Date

_____

Print Physician's Name

_____

Address