Cedar Rapids Community Schools

Diet Prescription Form

PART 1 – To Be Completed By Parent/Guardian

Student Name:	Parent/Guardian Name:
Date of Birth:	Address:
School Attending:	
Grade:	Telephone:

PART 2 - Must Be Completed By a Licensed Prescribing Medical Professional (MD, DO, PA, ARNP)

Only diet modifications supported by the signature of a Licensed Prescribing Medical Professional can be implemented.

1) Diet Prescription: Complete PART 3 on reverse side to describe level of sensitivity/tolerance to food item(s).
(check all that apply)

☐Food Allergy (describe): _____
Food Anaphylaxis ☐
☐Food Intolerance (describe): _____
☐Other (describe): _____
☐Modified Texture, Consistency and/or Special Feeding Equipment (attach meal plan)
☐Diabetic Diet (attach meal plan)

Omitted Food(s) and Substitutions:
List the specific food(s) to be omitted and food(s) that may be substituted. See reversed side for specific food descriptions based on sensitivity level.

Omitted Food(s)	Substitutions
_____	_____
_____	_____

2) Describe the medical need related to the diet order and major life activity affected.
(*Example: Allergy to peanuts affects ability to breathe.)*
_____
_____

Explain what must be done to accommodate the medical need:
_____

Additional Comments: _____
_____

I certify that the above named student requires special accommodations as described on front & back of form.

Licensed Prescribing Medical Professional: _____
Name (Print or Type) Title

_____ _____ _____
Signature of Medical Professional Telephone Number Date

Consent to release information on this form between school personnel & the child's health care provider.

Parent/Guardian Signature: _____ **Date**: _____

USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods: ☐
For safety, supplied food(s) cannot be stored or prepared in district kitchens.

PART 3 - **Must Be Completed By a Licensed Prescribing Medical Professional (MD, DO, PA, ARNP)**

☐ Checking here indicates the Medical Professional chooses **not** to use this side of the form, making any documentation below obsolete.

Please check the box in front of the food groups that should NOT be served.

Our priority is student safety; with a goal to provide the least restrictive & well-rounded meal possible.

Lactose/milk – *Do not serve the following checked items:*

- ☐Fluid Milk to drink
- ☐Milk based desserts such as: ice cream and pudding
- ☐Yogurt
- ☐Hot entrees w/ cheese as a prime ingredient (grilled cheese, cheese pizza, macaroni & cheese)
- ☐Cheese baked in products such as a casserole or on meat pizza
- ☐Cold cheese such as: string cheese or sliced cheese on a sandwich
- ☐Butter or Margarine
- ☐Milk in products such as: breads, mashed potatoes, cookies or graham crackers

Soy - *Do not serve the following checked items*:

- ☐Protein products extended with soy
- ☐Processed items cooked in soy oil
- ☐Food products with soy as one of the first three ingredients
- ☐Food products with soy listed as the fourth ingredient or further down the list

Egg - *Do not serve the following checked items:*

- ☐Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold
- ☐Eggs used in breading or coating of products
- ☐Baked products with eggs such as breads or desserts

Shellfish or fish – *Do not serve the following checked items:*

- ☐Specific fish or seafood type:_____

Peanuts – *Do not serve the following checked items:*

- ☐Peanuts, individually or as an ingredient
- ☐Foods containing peanut oil
- ☐Foods items identified as manufactured in a plant that also handles peanuts

Tree nuts – *Do not serve the following checked items:*

- ☐Specify type(s):_____
- ☐Foods items identified as manufactured in a plant that also handles nuts

Wheat – *Do not serve the following checked items:*

- ☐Foods containing wheat
- ☐Foods containing gluten
- ☐Other: _____

Additional Considerations**:**

_____ _____

Signature of Medical Professional **Date**