Louisiana Department of Education
School Food Service Section
Diet Prescription for Meals at Red River Parish Schools

Student's Name _______________________________ Age ________________

School ___________________________________________ Grade/Classroom ________

Parent's Name _________________________________________

Address ____________________________________________ Telephone (_____ ) ____________

(Street or P. O. Box)

City _____________________________________________ State __________________________

Does the student have a disability that requires a special diet? Yes_______ No_______
If Yes, describe the major life activities affected by the disability. (See back of form for further information.)

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs. _____________________________________________________________

Diet Prescription (Check all that apply.):

() Diabetic
() Increased Calorie ________ #kcal
() Food Allergy
() Reduced Calorie ________ #kcal
() Hypoglycemic
() Texture Modification
() Chopped ______ Ground ______
() PKU
() Pureed ______ Liquified ______
() Other__________
() Tube Feeding
() Liquified Meal ______ Formula ______

Foods Omitted and Substitutions
(Please check food groups to be omitted. Identify specific foods to omit and list foods to be substituted. If necessary, attach additional information or instructions regarding the diet or feeding.)

Food Groups to Omit
() Meat and Meat Alternatives
() Milk and Milk Products
() Bread and Cereal Products
() Fruits and Vegetables

Specific Foods to Omit

Specific Foods to Substitute

________________________________________

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.

Office Address ____________________________________________ Office Telephone # (_____ ) ____________________________

________________________________________

1Licensed Physician/Recognized Medical Authority Signature Date

1Signature of Licensed Physician required if the student is disabled.
Definition of Disability

Definitions

As used in this part, the term or phrase:

(l) **Student with disabilities** means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(j) **Physical or mental impairment** means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.

(k) **Major life activities** means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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**mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

**fax:** (833) 256-1665 or (202) 690-7442;

**email:** program.intake@usda.gov

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