

**LOUISIANA DEPARTMENT OF EDUCATION
SCHOOL FOOD SERVICE SECTION
DIET PRESCRIPTION FOR MEALS AT SCHOOL**

Student's Name _____ Age _____

School _____ Grade/Classroom _____

Parent's Name _____

Address _____ Telephone _____

City _____ State _____ Zip Code _____

Does the student have a disability that requires a special diet? No Yes

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 _____

_____ Date _____

¹Licensed Physician/Recognized Medical Authority Signature

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

CC: School Nurse, Cafeteria Manager, SFS Director, Student's folder, Physician

Definition of Disability

Definitions

As used in this part, the term or phrase:

(i) *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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To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.