

**CITY OF BAKER SCHOOL SYSTEM
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 (_____) _____
(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.):

- | | |
|---------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Increased Calorie _____ #kcal |
| <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Reduced Calorie _____ #kcal |
| <input type="checkbox"/> Hypoglycemic | <input type="checkbox"/> Texture Modification |
| <input type="checkbox"/> PKU | Chopped _____ Ground _____ |
| <input type="checkbox"/> Other _____ | Pureed _____ Liquified _____ |
| | <input type="checkbox"/> 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 | <input type="checkbox"/> Meat and Meat Alternatives | <input type="checkbox"/> Milk and Milk Products |
| <input type="checkbox"/> Bread and Cereal Products | <input type="checkbox"/> 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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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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