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) **Does the participant have a disability?** ☐ **No** (Skip to question 2)
☐ **Yes** (Identify below, the following information is required)

Identify Disability: _____

Describe the major life activity or functions affected by the disability: (see link for definitions of disability http://www.eeoc.gov/laws/statutes/adaaa_info.cfm)

_____

_____

Explain why the disability restricts the participant's diet:

_____

2) **Diet Prescription** (check all that apply) See PART 3 on reverse side to define level of sensitivity to food items.

☐Food Allergy (describe): _____
Food Anaphylaxis ☐
☐Food Intolerance (describe):_____
☐Other (describe): _____
☐Modified Texture and/or Liquids (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
_____	_____
_____	_____
_____	_____

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**: _____

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
- ☐Butter or Margarine
- ☐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
- ☐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**