



**MONTGOMERY
PUBLIC SCHOOLS**

Diet Prescription for Meal Pick Up

Date: _____ LEA: _____

Name of Student: _____ Preferred School Pickup: _____

Information below to be completed by recognized medical authority

Disability or medical condition that requires the student to have a special diet - Include a brief description of the major life activity affected by the student's disability

Diet Prescription (Check all that apply)

- Diabetic Reduced Calorie
- Increased Calorie Modified Texture
- Other (Describe)

Foods Omitted (Please check food groups to be omitted.)

- Meat and Meat Alternates Milk and Milk Products
- Bread and Cereal Products Fruits & Vegetables
- Other (Describe)

Substitutions (Please provide suggested substitutions for omitted foods or attach information.)

Textures Allowed (Check the allowed texture)

- Regular Chopped Ground Pureed

Other Information Regarding Diet or Feeding

(Please provide additional information on the back of this form or attach to this form.)

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.

Physician/Recognized Medical Authority Signature

Office Phone

Date

****The diet prescription must be renewed annually.***

