BELLINGHAM SCHOOL DISTRICT
Diet Prescription for Meals at School - Nutrition Services

Parent Instructions:

1. ***If your child needs a special Diet Prescription for SCHOOL MEALS due to a health condition requiring a special diet, complete this form.***
2. ***The Diet Prescription should be completed and signed by a Physician or Recognized Medical Authority.***
3. ***Return the completed form to the school secretary.***

School Secretary:

1. ***Make three copies of the Diet Prescription; one for the School Nurse, one for the Food Service Lead, and one for the office.***
2. ***Send the original to the Food Services Department at Central Services, Attention: Food Service Manager.***

Student name: _____ Birthdate:_____
School: _____ Grade: _____

To be completed by the child's Physician (if describing a disability) or a recognized Medical Authority

Section A: Health condition requiring a special diet:

Food allergy

☐ Has a life threatening /severe reaction to: _____

☐ Has a mild reaction and needs to avoid: _____

Other: _____

Section B: Diet Prescription -Enter below additional instructions if necessary.

_____

_____

Foods to Omit:	**Foods to Substitute:**
_____	_____
_____	_____
_____	_____

I certify that the above named student needs special school meals prepared or served as described above because of the student's disability or chronic medical condition.

_____ _____
Physician or Recognized Medical Authority Signature Date signed

Name: _____ Office Phone: _____ Fax: _____
Type or Print

I understand that if my child's medical or health needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed.

_____ _____ _____
Parent/Guardian's Signature Home Phone Number Date signed

Original – Food Services (Roeder) Computer Entry _____ Copy: Food Service Lead _____
Date Copy: School Secretary _____
Nurse Notified: _____