OFFICE USE ONLY: Initial and Date	
_____ School Nurse/Responsible Staff	_____ Date Received
_____ Cafeteria Manager	_____ Date Received
_____ Central Office	_____ Date Received

Child Nutrition Program
Diocese of Baton Rouge

2026 – 2027 School Year
Diet Prescription for Meals at School

Section 1 To Be Completed by the Parent	**Student Information** Student Name:_____Age:_____ School Name:_____Grade:_____ Parent/Guardian Name:_____Phone:_____ Address:_____ Email Address:_____ Does the student have a disability or medical condition that requires a special diet? ☐**Yes** ☐**No**
Section 2	**Food Intolerance:** Digestive system response, i.e. nausea, diarrhea, bloating, headaches, rashes, etc.
Section 2(a) Food INTOLERANCE	**Food Intolerance- Eliminate intolerable food only.** Check all that apply: ☐ **Lactose Intolerance** *(eliminate fluid milk)* ☐ **Yes** ☐ **No** **Allow** other dairy items (such as cheese, yogurt, sour cream, non-fat milk, dry milk, whey, casein, milk solids, etc. ☐ **Substitutions** _____ ☐ **Egg Intolerance** *(eliminate eggs in pure form)* ☐ **Yes** ☐ **No** **Allow** eggs as an ingredient in foods (such as cookies, cake, muffins, cornbread, French toast, pancakes, waffles, pastas, meatballs, breading on chicken products, entrees, ranch dressing, mayonnaise, etc.). ☐ **Substitutions** _____ ☐ **Wheat Intolerance** ☐ **Yes** ☐ **No** **Eliminate** breads, buns, rolls, cornbread, pizza, corn dogs, pasta, crackers, muffins, donuts, cereal bars, most breakfast cereals, French toast, waffles, pancakes, cookies, brownies, cakes, flour tortillas, etc. ☐ **Yes** ☐ **No** **Allow** foods containing small amounts of wheat such as batter breading on entrees, meatloaf, roux in gumbo, etc. ☐ **Substitutions** _____
Section 3	**Food Allergy: Immune System Response**
Section 3(a) FOOD ALLERGY	**Food Allergy - Eliminate all ingredients/products with food allergen.** Check all that apply: ☐Dairy ☐History of inhalation reaction ☐Wheat ☐History of inhalation reaction ☐Eggs ☐History of inhalation reaction ☐Peanuts ☐History of inhalation reaction ☐Shellfish ☐History of inhalation reaction ☐Soy ☐History of inhalation reaction ☐Fish ☐History of inhalation reaction ☐Tree Nuts ☐History of inhalation reaction ☐Sesame ☐History of inhalation reaction ☐Other _____ ☐**Substitutions**_____
Section 4 **CHANGE** in Diet Prescription	**Special Diet Status has CHANGED as indicated:** ☐ **Student *no longer needs* special diet** ☐ ***Update* the special diet as reflected on this form**
Section 5 **Medical Certification**	*I certify that the above-named student needs modified school meals prepared as described above because of the student's disability, chronic medical condition and/or allergy.* Provider Name (Print)_____ Address_____Phone _____ _____Date_____ **Recognized Medical Authority Signature** ("Recognized Medical Authority" shall mean a state licensed healthcare professional or registered dietitian (7 CFR 210.10(m)(1i), and a "state licensed healthcare professional" shall include a physician, physician's assistant, or advanced practice registered nurse authorized to prescribe under La. Admin. Code tit. 46 § LIII-2745.) **X**_____

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