

JEFFERSON PARISH PUBLIC SCHOOLS
Medical Statement to Request School Meal Modification
School Year 2018-2019

Meal service to students with special dietary needs is provided to all school sites. Federal and State regulations require a completed diet prescription form for any type of change or substitution to the student's diet. The special diet prescription form will need to be completed by your child's physician or medical authority and returned to your school cafeteria. Parents will need to provide any necessary meals for student until the form is processed. If you have questions regarding the form, please contact the Food Services Office at (504) 349 - 7768.

Student's Name: _____ Date of Birth: _____

PRESCRIBED DIET ORDER – <i>This part MUST be completed and signed by a medical authority as specified above.</i>				
1. Specify the physical or mental impairment related to the prescribed diet order and describe the type of special diet/restriction required (i.e. food intolerance, food allergy, food restrictions due to a disease process):				
2. Foods to be Omitted and Substituted: Check specific foods to be omitted and list approved substitutions below. If more space is needed, sign and attach additional sheet of paper. <input type="checkbox"/> Check if not applicable				
Dairy (please specify) <input type="checkbox"/> Fluid Milk <input type="checkbox"/> Cheese <input type="checkbox"/> Yogurt <input type="checkbox"/> All milk proteins (including dairy as an ingredient)				
If fluid milk is to be restricted, check approved substitution <input type="checkbox"/> Juice <input type="checkbox"/> Water <input type="checkbox"/> Lactose-Free Milk <input type="checkbox"/> Soy Milk				
Eggs (please specify) <input type="checkbox"/> Whole eggs –hard boiled or scrambled and/or <input type="checkbox"/> Egg as ingredient-albumin (white) & yolk				
Other Allergens: <input type="checkbox"/> Wheat <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Finfish <input type="checkbox"/> Shellfish <input type="checkbox"/> Soy*				
*Soy Allergy: Research states that soy <i>lecithin</i> and <i>soybean oil</i> is well tolerated by persons with soy allergy. If student avoids these ingredients please check here <input type="checkbox"/>				
Specific food(s) to be omitted: <i>(please be as specific as possible)</i>		Approved substitutions:		
3. Calorie Count Allowed/Meal: Breakfast _____ kcals Lunch _____ kcals <input type="checkbox"/> Check if not applicable				
4. Carbohydrate Grams Allowed/Meal: Breakfast _____ grams Lunch _____ grams Snack (required/not required) AM _____ /PM _____ grams <input type="checkbox"/> Check if not applicable				
5. Sodium Milligrams Allowed/Meal: Breakfast _____ grams Lunch _____ grams <input type="checkbox"/> Check if not applicable				
6. Total Fat Grams Allowed/Meal: Breakfast _____ grams Lunch _____ grams <input type="checkbox"/> Check if not applicable				
7. Modified Texture:	<input type="checkbox"/> Chopped	<input type="checkbox"/> Ground	<input type="checkbox"/> Pureed	<input type="checkbox"/> Not Applicable
8. Modified Thickness of Liquids:	<input type="checkbox"/> Nectar	<input type="checkbox"/> Honey	<input type="checkbox"/> Spoon or Pudding Thick	<input type="checkbox"/> Not Applicable
9. List Tube Feeding Formula: Number of Cans/Meal: Breakfast _____ can(s) Lunch _____ can(s) <input type="checkbox"/> Check if not applicable				
10. List Special Feeding Equipment: <input type="checkbox"/> Check if not applicable				
MEDICAL AUTHORITY'S CONTACT INFORMATION				
Printed Name:		Title:		
Office Address:		Office Phone Number:		
Signature:			Date:	

JEFFERSON PARISH PUBLIC SCHOOLS
Parent/Guardian Permission for Prescribed Diet Order
School Year 2018-2019

Student's Name: _____ Date of Birth: _____ School: _____

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals.

I give permission for my child's medical authority to further clarify the prescribed diet order if requested to do so by school personnel.

I give permission for my child to wear a visible identifier during the meal period in order to ensure that my child receives the prescribed diet order. **(ONLY FOR STUDENTS ATTENDING A SCHOOL PARTICIPATING IN THE CEP PROGRAM)**

Parent/Guardian's Name (Printed): _____

Parent/Guardian's Address: _____

Parent/Guardian's Phone: _____ Parent/Guardian's Email: _____

Parent/Guardian's Signature: _____ Date: _____