Riverview School District
Diet Prescription for Meals at School

Student Name_____Age_____
School_____Grade_____
Disability_____
Major Life Activity Affected_____
OR Non-Disabling Medical Condition_____
Brief Description of Medical Condition_____

Physician Request Diet Prescription (check all that apply):

☐ Increased calorie_____#kcal
☐ Decreased calorie_____#kcal
☐ Diabetic
☐ PKU
☐ Food Allergy
☐ Other_____

Texture Modification:
☐ Chopped
☐ Ground
☐ Pureed
☐ Liquefied

Tube Feeding:
☐ Liquefied meal
☐ Formula_____

Foods to Omit:

_____
_____
_____
_____

Foods to Substitute:

_____
_____
_____
_____

I certify the above-named student needs special school meals prepared as described above because of the student's disability or non-disabling medical condition.

_____ _____
Licensed Physician or Medical Authority Signature Date Phone Number

_____ _____
Parent Signature Date Phone Number

Cc: School Office, Kitchen, Food Services District Office