Los Lunas Schools
Special Diet Prescription Form

Please have this form completed and signed by a licensed physician for a child with a disability or a medical/dietary need in order for a student to receive modifications or substitutions to the regular school meals.

Date:_____

Student Name:_____ Student Number:_____

Date of Birth:_____ School:_____

Diagnosis(es):_____ ICD-9 code(s):_____

Parent/Guardian:_____Phone Number:_____

Describe the Student's ____ **Disability** ____ **Medical Condition** that requires the student to have a special diet and the major life activity affected by the student's disability or condition:

_____

_____

History of anaphylaxis reaction due to severe food allergy: ____ Yes ____ No
If yes, please provide documentation.

History of allergy testing to indicate food allergy: ____ Yes ____ No

Intolerance to foods? If yes, which foods? _____

List food(s) to be omitted from the diet and food(s) that may be substituted:

Omit: _____

Alternatives: _____

Registered Dietitian consulting with the patient:

Name: _____Phone Number:_____

Licensed Physician/Practitioner Signature: _____

Phone Number:_____Fax Number:_____

Licensed Physician/Practitioner (Print Name):_____

Mailing Address:_____

***Provider, please return completed and signed prescription form to the School Nurse**

Copies to: LLS School Nurse, LLS Student Nutrition Director, School Cafeteria Manager, Teacher (Must remind staff about confidentiality and securing this form in a locked location)

Revised 7/20/20