North Kitsap School District

Food/Nutrition Services
18360 Caldart Ave
Poulsbo, WA 98370

Diet Prescription for Meals at School

School_____

Student's Name_____ **Age**_____ **Grade**____

Disability_____

Major life activity affected_____
OR
Non-disabling medical condition_____

Diet Prescription (check all that applies):

- ☐ **Diabetic**
- ☐ **Texture modification: ____Chopped ____ Ground ____Pureed**
- ☐ **Other**_____

Foods to OMIT	**Foods to SUBSTITUTE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Signature of Physician/
Recognized Medical Authority_____

Office Telephone_____ Date _____

ORIGINAL to F/N Office COPY to School Kitchen COPY to School office COPY to Parent/Guardian