

**LIVINGSTON PARISH PUBLIC SCHOOLS  
SCHOOL FOOD SERVICE  
DIET PRESCRIPTION FORM  
SY 2018-2019**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Parent's or Guardian's Name \_\_\_\_\_ Contact # \_\_\_\_\_

Does the student have a disability that requires a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, describe the major life activities affected by the disability. (See back of form for further information.)

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

Diet Prescription (Check all that apply):

- Diabetic
- Lactose Intolerance (eliminate fluid milk)  
Other dairy allowed **(Must check one)**: cooked cheese, etc. \_\_\_\_\_ YES \_\_\_\_\_ NO
- Calorie Count  
Increased Calorie \_\_\_\_\_ #kcal Reduced Calorie \_\_\_\_\_ #kcal
- Food Textures **(Must check one)**  
Diced ½" x ½" \_\_\_\_\_ Finely Chopped ¼" x ¼" \_\_\_\_\_  
Pureed (Smooth) \_\_\_\_\_ Pureed (Textured) \_\_\_\_\_
- Liquid Textures **(Must check one)**  
Thin (Regular) \_\_\_\_\_ Nectar \_\_\_\_\_ Honey \_\_\_\_\_ Pudding \_\_\_\_\_
- Tube Feeding: Formula \_\_\_\_\_
- Religious Reason (No Physician Signature Required) \_\_\_\_\_
- Other \_\_\_\_\_

**FOOD INTOLERANCE**

<input type="checkbox"/>	Milk (fluid form only) – <b>cheese allowed</b>
<input type="checkbox"/>	Milk <b>AND</b> Dairy Products
<input type="checkbox"/>	Eggs
<input type="checkbox"/>	Wheat
<input type="checkbox"/>	Soy
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____

<input type="checkbox"/>	Milk
<input type="checkbox"/>	Eggs
<input type="checkbox"/>	Fish
<input type="checkbox"/>	Shellfish
<input type="checkbox"/>	Tree Nuts
<input type="checkbox"/>	Peanuts
<input type="checkbox"/>	Wheat
<input type="checkbox"/>	Soy
<input type="checkbox"/>	Other: _____

**FOOD ALLERGY**

<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction
<input type="checkbox"/>	History of inhalation reaction

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

Office Address \_\_\_\_\_

Office Telephone # \_\_\_\_\_

\_\_\_\_\_  
¹Licensed Physician/Recognized Medical Authority Signature

\_\_\_\_\_  
Date

¹Signature of Licensed Physician required if the student is disabled.

## Definition of Disability

As used in this part, the term or phrase:

**(i) Student with disabilities** means any person who has a physical or mental impairment, which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

**(j) Physical or mental impairment** means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems:

Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term *physical or mental impairment* includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.

**(k) Major life activities** means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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Mail U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 202510-9410

Fax (202)690-7442

Email [Program.intake@usda.gov](mailto:Program.intake@usda.gov)

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