Livingston Parish Public Schools

PRESCRIPTION FOR SCHOOL MEAL MODIFICATION

Please return to the school. For the safety of the student, this form MUST be thoroughly, legibly completed.
This document is in effect for the **2023-2024** school year and must be renewed annually.

Student's Name: _____ Date of Birth: _____

School: _____ Student ID #: _____

Parent's Name: _____ Telephone: _____

Disability/Medical Condition(s) Requiring Special Dietary Needs:

_____

Diet Prescription (Mark All That Apply)

FOOD INTOLERANCE

Lactose Intolerance

Eliminate fluid milk only (allow other dairy products) ☐ Yes ☐ No

Allow other dairy items (i.e. cheese, yogurt, non-fat dry milk, whey, casein, ice cream) ☐ Yes ☐ No

Allow entrees with cooked dairy items: (i.e. macaroni & cheese, pizza) ☐ Yes ☐ No

Egg Intolerance

Eliminate eggs in the PURE FORM only ☐ Yes ☐ No

Allow eggs as an ingredient in foods (i.e. cookies, cakes, cornbread, French toast, pancakes, pastas, meatballs, breading on chicken products/entrees, mayonnaise, ranch dressing, etc.) ☐ Yes ☐ No

Wheat Intolerance ☐ Yes ☐ No

Eliminate breads, buns, cornbread, pizza, breading, pasta, crackers, donuts, cereal bars, most breakfast cereals, French toast, pancakes, cookies, brownies, cakes, flour tortillas

Allow foods containing small amounts of wheat (i.e. batter/breading or entrees, meatloaf, roux, etc.)

FOOD ALLERGY (Immune System Response)

Eliminate Ingredients with Food Allergen

☐ **Dairy Products** (**no** milk, no cheese, no yogurt, no whey, no NFDM, no casein allowed as an ingredient, etc.)

☐ **Eggs** (**no** cookies, cornbread, French toast, pancakes, pasta, breading, mayonnaise, ranch dressing, etc.)

☐ **Wheat**	☐ **Shellfish**
☐ **Soy Protein** (allow soybean oil)	☐ **Tree Nuts**
☐ **Fish**	☐ **Peanuts**
☐ **Other:**	☐ **Other:**

TEXTURE MODIFICATION

☐ **Food Textures: (Check One)** ☐ Diced 1/2" x 1/2" ☐ Finely Chopped 1/4" x 1/4" ☐ Puree Smooth ☐ Puree Textured

☐ **Liquid Textures: (Check One)** ☐ Thin ☐ Nectar ☐ Honey ☐ Pudding

OTHER

☐ **Diabetic:** _____ ☐ **Other:** _____

☐ **Religion:** _____ ☐ **Other:** _____

No signature required

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

_____ _____

Licensed Physician/Recognized Medical Authority Signature **Date**

Office Address: _____ **Phone** _____

_____ **Fax:** _____