Form A: Dietary Prescription for **Student WITH Disability**

OSPI Child Nutrition Programs

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name	Birth Date	Age	Grade	School

Parent/Guardian Name	Phone

Mailing Address	City/State/Zip

Signature of Parent/Guardian	Date

DIET ORDER – LICENSED PHYSICIAN MUST COMPLETE and SIGN THIS SECTION.

1. List student's disability: _____
   (Include life-threatening allergies which cause an immune system response to a particular food/ingredient/additive.)

2. What is the major life activity(s) affected?

3. Describe how the disability restricts student's diet:

4. List all food(s) and/or milk to be <u>omitted</u>:

5. List all food(s) and/or milk to be <u>substituted</u>:

6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

7. Describe any other comments about the student's eating or feeding patterns:

Signature of Licensed Physician	Date	E-mail	Phone

Printed Name of Licensed Physician	Address

Form B: Dietary Prescription for **Student WITHOUT Disability**

OSPI Child Nutrition Programs

IS THIS REQUEST FOR COWS MILK SUBSTITUTION (check box): Yes ☐ No ☐

FOR INTERNAL INFORMATION ONLY: If yes, the local education agency must request approval from the Office of Superintendent of Public Instruction - Child Nutrition Services prior to making milk substitutions and must follow USDA regulations. Requests for milk substitutions may be signed by a parent/guardian OR recognized medical authority for students without disabilities.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name _____ Birth Date _____ Age _____ Grade _____ School _____

Parent/Guardian Name _____ Phone _____

Mailing Address _____ City/State/Zip _____

Signature of Parent/Guardian _____ Date _____

DIET ORDER - RECOGNIZED MEDICAL AUTHORITY MUST COMPLETE and SIGN THIS SECTION.

The definition of a Recognized Medical Authority in Washington State is limited to the following professionals only: Medical Doctor; Doctor of Osteopathy; licensed Physician's Assistant with prescriptive authority; licensed Advanced Registered Nurse Practitioner with prescriptive authority; or licensed Naturopathic Physician.

1. What is the student's special dietary need?

2. List all food(s) to be omitted:

3. List all food(s) to be substituted:

4. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

5. Describe any other comments about the student's eating or feeding patterns:

Signature of Recognized Medical Authority _____ Date _____ E-mail _____ Phone _____

Printed Name of Recognized Medical Authority _____ Address _____