South Kitsap School District No. 402

1962 Hoover Ave. SE, Port Orchard, WA 98366-3034 • (360) 874-7000 • Fax: (360) 874-7068

FORM 622

Diet Prescription for Meals at School

Student Name: _____ **Birth Date:** _____ **School:** _____ **Grade:** _____

Disability: _____

Major life activity affected: _____

or

Non-Disabling Medical Condition: _____

Diet Prescription: (Check all that apply.)

- ☐ **Increased Calorie** _____#kcal
- ☐ **Diabetic**
- ☐ **PKU** _____
- ☐ **Food Allergy**
- ☐ **Other**_____
- ☐ **Decreased Calorie** _____#kcal
- ☐ **Texture Modification:**
  - ☐ **Chopped**
  - ☐ **Ground**
  - ☐ **Pureed**
  - ☐ **Liquified**
  - ☐ **Tube Feeding**
    - ☐ **Liquified Meal**
    - ☐ **Formula** _____ **type**

Foods to Omit:

_____
_____
_____
_____
_____
_____

Foods to Substitute:

_____
_____
_____
_____
_____
_____

Classroom Teacher:_____ **Homeroom Teachers:**_____

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

_____

Physician/Recognized Medical Authority Signature

Office Telephone: _____ **Date:** _____