



**MONTGOMERY  
PUBLIC SCHOOLS**

**Diet Prescription for Meal Pick Up**

Date: \_\_\_\_\_ LEA: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Preferred School Pickup: \_\_\_\_\_

*Information below to be completed by recognized medical authority*

**Disability or medical condition that requires the student to have a special diet - Include a brief description of the major life activity affected by the student's disability**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diet Prescription (Check all that apply)**

- Diabetic                       Reduced Calorie
- Increased Calorie       Modified Texture
- Other (Describe)

**Foods Omitted (Please check food groups to be omitted.)**

- Meat and Meat Alternates       Milk and Milk Products
- Bread and Cereal Products       Fruits & Vegetables
- Other (Describe)

**Substitutions *(Please provide suggested substitutions for omitted foods or attach information.)***

**Textures Allowed *(Check the allowed texture)***

- Regular     Chopped     Ground     Pureed

**Other Information Regarding Diet or Feeding**

*(Please provide additional information on the back of this form or attach to this form.)*

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.

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

\_\_\_\_\_  
Office Phone

\_\_\_\_\_  
Date

***\*The diet prescription must be renewed annually.***

