Valley School District No. 070
3030 Huffman Road • Valley, WA 99181 • Ph: (509) 937-2791 • Fax: (509) 937-2204 • www.valleysd.org

Diet Prescription for Meals at School

To assist staff with the care and safety of your child at school, please obtain the following diet prescription information from the child's licensed healthcare provider, and return this signed form to the school office annually and/or more often as needed to support his/her dietary needs.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION:

Student Name: _____ Birthdate: _____ Age: _____

Grade: _____ School/Teacher: _____ School Term 20____ / 20____

Parent/Guardian Name:_____ Phone: _____

Address: _____ Signature: _____

A STATE LICENSED HEALTH CARE PROFESSIONAL LICENSED TO WRITE MEDICAL PRESCRIPTIONS MUST COMPLETE AND SIGN THIS SECTION:

DIET ORDER

Student's Disability: _____ ☐ *Student is without disability*

Major Life Activity(s) Affected: _____

Describe how the disability restricts student's diet:_____

_____

List all foods and/or milk to be omitted:

_____

_____

_____

List all foods and/or milk to be substituted:

_____

_____

_____

(*check all that apply*):

☐ Increased Calorie - Number of kcals: _____

☐ Decreased Calorie - Number of kcals: _____

☐ Diabetic ☐ PKU ☐ Other: _____

Texture Modification:
☐ Chopped ☐ Ground
☐ Pureed ☐ Liquefied

☐ Food Allergy: _____

☐ Tube Feeding: ☐ Liquefied Meal ☐ Formula / Type _____

Additional alternate foods or instructions about the student's eating or feeding patterns:_____

_____

_____

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.

Licensed Healthcare Professional:

_____ _____

Printed Name / Title / Office *Phone No.*

_____ _____

Signature *Date*

Form #3413F2