**SPECIAL MEALS PRESCRIPTION FORM**

Local School District/Name of Institution: ________________________________

Street Address: _______________________________________________________

City: ____________________________________________ NH Zip Code:_________

Student Name: ____________________________________________ DOB:_________

SASID: ___________ School Name/Institution: (if different than above) ________

Disability: □ Disabled (Federal Policy: as determined by physician)  □ Non-disabled (school district policy)

Disability or medical condition:

- □ Food Allergy
- □ Food Intolerance
- □ Celiac Disease
- □ Tube Feeding
- □ Diabetes
- □ Cerebral Palsy
- □ Cystic Fibrosis
- □ Spina Bifida
- □ Autism/PDD
- □ Failure to Thrive
- □ Down Syndrome
- □ PKU
- □ Galactosemia
- □ None
- □ Other (specify): __________________________

Description of Condition Requiring Special Diet: ____________________________

Special Diet: (Check all that apply) □ Diabetic □ Reduced Calorie □ Increased Calorie □ Modified Texture

Date Effective: From:______________ To:______________

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**MEATS/PROTEIN FOODS**

Can't Have: □ Chicken □ Pork □ Canned/Dried Beans □ Nuts/Seeds
- □ Beef □ Poultry □ Peanut Butter □ Soy (Tofu, Soy Protein)
- □ Fish □ Eggs □ No Restriction □ Any Meat/Protein Foods
- □ Other (specify): ____________________________________________

Food Prep: □ Pureed □ Ground □ Thin Strips ¼” □ Bite Size, ¼” by ½” □ None

Apply this preparation to all Meat/Protein Foods: □ Yes □ No

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**VEGETABLES/FRUIT**

Can't Have: □ Fruits, fresh □ Any fruits/vegetables
- □ Canned □ Vegetables, hard/uncooked
- □ Canned with liquids □ Other (specify): ____________________________

Food Prep: □ Pureed □ Ground □ Thin Strips ¼” □ Bite Size, ¼” by ½” □ None

Apply this preparation to all Vegetables/Fruit: □ Yes □ No

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**GRAINS/BREADS/CEREALS**

Can't Have: □ Bread/Rolls □ Crackers □ Taco Shells, hard
- □ Gluten (barley, rye, wheat) □ Rice □ Tortillas, soft
- □ Pancakes/Waffles □ Pasta □ French Toast
- □ Cereal □ No Restriction □ Any Bread/Grains/Cereal Foods
- □ Other (specify): ____________________________

Food Prep: □ Pureed □ Ground □ Thin Strips ¼” □ Moistened □ None
- □ Bite Size, ¼” by ½” □ Toasted/grilled

Apply this preparation to all Grains/Breads/Cereals: □ Yes □ No
**MILK/DAIRY**

Can't Have:  
- Cheese  
- Cheese, soft  
- Cheese, hard  
- Any Milk/Dairy Foods

Food Prep:  
- Pureed  
- Ground

Apply this preparation to all Milk/Dairy:  
- Yes  
- No

**FATS/SAUCES**

Can't Have:  
- No Restrictions  
- Low fat Dressings  
- High fat Dressings  
- Spreads

**COMBINATION FOODS**

Can't Have:  
- Gluten  
- Shepherds Pie  
- Stews

Food Prep:  
- Pureed  
- Moistened w/sauce or gravy  
- Ground

Apply this preparation to all Combination Foods:  
- Yes  
- No

**LIQUIDS**

Tube Feeding:  
- Yes  
- No

Liquids by Mouth Allowed:  
- Yes  
- No

Select Type of Thickeners Needed:  
- Thickened Syrup  
- Thickened Nectar*

Select Thickeners:  
- Dry instant baby cereal  
- Fruit pureed/Stage I/II baby  
- Yogurt

- Dry instant mashed potato  
- Simply Thick  
- Any Thickener listed

- Dry instant pudding  
- Thick It

*Nectar = thicken enough to coat a spoon, Honey = thicken enough to stand a straw straight in a cup

Thickening Directions:
# SAFE EATING PLAN

*(To be completed by Special Education Team or 504 Coordinator)*

<table>
<thead>
<tr>
<th>Describe any special positioning needed while eating/drinking:</th>
<th>Provide safe eating environment by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Peanut Free Table</td>
</tr>
<tr>
<td></td>
<td>☐ Quiet Table/Area</td>
</tr>
<tr>
<td>Describe any special utensils or feeding equipment needed:</td>
<td>☐ Other:</td>
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<tr>
<td>Describe any special methods for presenting food/drink:</td>
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<td></td>
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<tr>
<td>Liquids served, check all that apply:</td>
<td></td>
</tr>
<tr>
<td>☐ bottle</td>
<td></td>
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<tr>
<td>☐ sippy cup</td>
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<tr>
<td>☐ spoon</td>
<td></td>
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<tr>
<td>☐ with straw</td>
<td></td>
</tr>
<tr>
<td>☐ juice box holder</td>
<td></td>
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<tr>
<td>☐ other:</td>
<td></td>
</tr>
</tbody>
</table>

## PHYSICIAN/MEDICAL AUTHORITY SIGNATURE SECTION

☐ I certify that the above named student needs special meals prepared as described above because of the student's disability.

☐ I certify that the above named student would benefit from special meals as described above, however this child is not disabled. It is up to the discretion of each school/institution if and for what conditions they will provide substitutions.

Physician's/Medical Authority's Signature ___________________________ Office Phone Number ___________________________ Date ________________

Physician's/Medical Authority's Printed Name ___________________________

## PARENT/GUARDIAN SECTION

☐ YES Parent/Guardian accepts accommodations offered and his/her child will be participating in the Child Nutrition Program or any other program offered within the child's institution.

☐ Snack ☐ Breakfast ☐ Lunch ☐ Dinner

☐ NO Parent/Guardian declines accommodations offered and his/her child will not be participating in the Child Nutrition Program or any other program offered within the child's institution.

Parent's/Guardian's Signature ___________________________ Date ________________

CC:
☐ Parent/Guardian ☐ Physician ☐ Nutritionist
☐ Food Service Director ☐ School Nurse ☐ School Principal
☐ Feeding and Swallowing Specialist ☐ Special Ed Coordinator

For Official Use: Date returned to the Special Ed coordinator at the District Office: ___________________________