HUDSON CITY SCHOOL DISTRICT – FOOD SERVICE DEPARTMENT
MEDICAL DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of student for whom special foods at school are required or foods are to be excluded:

_____

Disability or **medical condition** that **requires** the student to have a special diet (include brief description of the major life activity affected by the student's disability, if applicable):

_____

_____

Is this condition temporary or permanent? _____

If this restriction is for a food allergy (complete all that apply):

Food(s) student is allergic to: _____

Is this allergy for ingestion only? _____

Is this allergy related to touching the food? _____

Other than restriction, is there any other precaution we should consider in providing care for this student?

_____

_____

_____

Foods to be omitted: _____

If substitutions are allowed, please describe: _____

_____

Diet restrictions, if applicable:

___Diabetic (describe) _____
___Reduced Calorie (describe) _____
___Increased Caloric Intake (describe) _____
___Modified Texture (describe) _____
___Allergies (describe) _____

– Please attach additional pertinent information regarding diet/feeding plan. –

I certify that the above student has a chronic medical condition or disability and needs special school meals prepared.

Practitioner's Signature: _____
Print Practitioner's Name: _____
Practitioner's Address: _____
Office Phone: _____

PLEASE FAX THIS FORM TO THE APPROPRIATE HEALTH OFFICE:

M.C. Smith Elementary School Fax Number: 518-697-8797

Hudson Junior High School Fax Number: 518-697-8791

Hudson Senior High School Fax Number: 518-697-8798