Danville Public Schools
Students with Special Dietary Needs
Diet Prescription

Student's Name: ____ Age: __________

School: ____ Grade: __________

Disability/***Life Threatening*** Food Allergy: ______________________________________

____

Or Medical Condition/Food Allergy: ____

____

Diet prescription (check all that apply):

☐ Diabetic

☐ Allergy – Omit Food

☐ Altered calorie needs - Amount: _____________________________________

☐ Texture Modification – Type: ____

☐ Other: ____

Notes:

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____________________________________ ______________

Physician/Licensed Health Professional Date

____________________________________ ______________

Parent/Guardian Signature Date

This institution is an equal opportunity provider.