



Return To:
1 North Loder Ave., Endicott, NY 13760
Food Services Department
(607) 766-3926

DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of Student: _____ School: _____ Grade _____

Disability or Medical Condition:

Metabolic Diseases

- Celiac Disease (Gluten Allergy) Diabetes (circle one: type I or type II)
- Other: _____

Food Allergies

- Egg Fish Peanut Shellfish Tree Nut Soy Wheat
- Milk Lactose Intolerance Other: _____

Is this condition permanent or temporary? Permanent Temporary

If temporary, please give length of time instructions are to be followed with explanation:

Diet Prescription: (Check all that apply)

- ___ Celiac Disease (Describe) _____
- ___ Diabetes (Describe) _____
- ___ Allergies (Describe) _____
- ___ Other (Describe) _____

Foods Omitted: _____

Substitutions: Specified Substitutions: _____
 Substitutions as per BOCES Registered Dietitian

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's Signature _____ Office Phone Number _____ Date _____

Print Physician's Name _____

Address _____

Return to Julie Raway, MPH, RDN, CDN, SNS
BOCES Food Services, 1 North Loder Ave., Endicott, NY 13760