

**This form must be faxed from the medical professional's office to  
School Food and Nutrition Services of New Orleans, Inc.**

**Phone 504-596-3452 Fax 504-596-3459**

**For the safety of this student, this form MUST be thoroughly and legibly completed.**

**PRESCRIPTION FOR SCHOOL MEAL MODIFICATION**

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ School City: \_\_\_\_\_ Grade/Classroom: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's E-mail \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(Street or P. O. Box) City Zip

**1. Medical Condition:** \_\_\_\_\_

**2. Diet Prescription (mark all that apply as Intolerance OR Allergy):**

**Food Intolerance:**

- \_\_\_ Eggs- pure form only
- \_\_\_ Milk- beverage form only\*  
\* Substitute (please circle): Juice or Water
- \_\_\_ Milk AND Dairy only\*  
\* Substitute (please circle): Juice or Water
- \_\_\_ Soy- pure form only
- \_\_\_ Wheat- whole or unprocessed only
- \_\_\_ Other \_\_\_\_\_

**Allergy: Eliminate ALL foods that may**

**contain any form of:**

- \_\_\_ Eggs Proteins
- \_\_\_ Fish
- \_\_\_ Milk Proteins
- \_\_\_ Nuts
- \_\_\_ Peanuts
- \_\_\_ Shellfish
- \_\_\_ Soy
- \_\_\_ Wheat
- \_\_\_ Other \_\_\_\_\_

Any Other Specific Dietary Need: \_\_\_\_\_

**3. Specific Foods to Omit**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Specific Foods to Substitute\***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Please note if juice or water may be substituted for liquid milk. If juice or water substitution is not noted on diet prescription form, student will be charged for juice or water.**

I certify that the above named student needs special meals prepared as described above because of the student's chronic medical condition.

Office Address: \_\_\_\_\_ Office Telephone: \_\_\_\_\_  
\_\_\_\_\_ Office Fax: \_\_\_\_\_

\_\_\_\_\_  
Licensed Physician/Recognized Medical Authority Signature

\_\_\_\_\_  
Date