Send completed form to:
Spokane International Academy
Director of Nutrition Services
2706 E Queen Spokane WA 99217
Phone: 509-209-8730 Fax: 509-209-8078

Diet Prescription for Meals at School

Section A: To be completed by the student's parent or guardian.

Student's Name: ______________________________ Date of Birth: ____________ Age: ______

Name of School: ______________________________________ Grade: ______________

Will student eat Breakfast at School? ☐ **Yes** ☐ **No;** Will student eat Lunch at School? ☐ **Yes** ☐ **No**

If you answered **No** to both of the above questions, **STOP**. Form is not required by Nutrition Services.

I understand that if my student's medical or health needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed.

______________________________ ____________________ ________________
Parent/Guardian's Signature Home Phone Number Date signed

☐ I give Nutrition Services permission to speak with the below named Licensed Physician or Recognized Medical Authority to discuss the dietary needs described. ____________________
(parent/guardian's initials and date)

Section B: To be completed by a Licensed Physician when identifying a disability OR a Recognized Medical Authority (RMA) when identifying a non-disabling medical condition. *For Diet Prescription purposes, a RMA includes a Licensed Physician, Doctor of Osteopathy, Licensed Physician's Assistant, ARNP or Licensed Naturopathic Physician.*

Student's Diagnosis? ____

Is the student's diagnosis recognized by the ADA as a disability?(**life threatening**) ☐ **Yes** ☐ **No**

If Yes, describe the major life activity affected by the disability ______________________________

Does the student have a non-disabling medical condition or special nutritional or feeding need? ☐ **Yes** ☐ **No**

If Yes, describe the condition or need ____

Diet Prescription- please attach additional instructions if necessary.

Foods to Omit:	**Foods to Substitute:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

If foods are listed to be omitted from the diet, **specifics on foods to substitute **must** be provided.

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

______________________________ ____________________
Licensed Physician or Recognized Medical Authority Signature Date

Name, including Credentials: ________________________ Phone: ____________ Fax: ____________
Type or Print

For office use: Date Received: ________________ Special Menu by RD?____yes ____no