Pinnacles Prep
504 S. Chelan Ave.
Wenatchee, WA 98801
509-888-6464

PINNACLES PREP

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? ☐ 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: Received: _____ Fast Track coding: _____
Date & Initials

Date entered in Fast Track: _____ _____

Revised 9-09 ww