Bremerton School District Child Nutrition Services
Diet Prescription for Meals at School

The section below must be completed by PARENT / GUARDIAN:

Student's Name:_____   **Date of Birth:**_____   **Age:**_____

Name of School:_____   **Grade:**_____

Does this student typically receive meals from Child Nutrition Services (CNS)?   ☐ **Yes**   ☐ **No**

If yes, which meal(s) provided by CNS will your student most likely eat?   ☐ **Breakfast** ☐ **Lunch**

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

Parent/Guardian Name:_____

Parent/Guardian Signature:_____   **Date:**_____

The section below must be completed by HEALTH CARE PROVIDER or LICENSED MEDICAL AUTHORITY:

Does the child have a disability?   ☐ **Yes**   ☐ **No**

   If yes, describe major life activity affected by disability:_____

Does the child have a non-disabling medical condition?   ☐ **Yes**   ☐ **No**

   If yes, describe medical condition:_____

Does the child have special nutritional or feeding needs?   ☐ **Yes**   ☐ **No**

   If yes, please specify:_____

Does the child have food allergies?   ☐ **Yes**   ☐ **No**

Does the child's food allergy cause anaphylaxis?   ☐ **Yes**   ☐ **No**

Please list food allergies:_____

Diet Prescription (Please attach addition instructions if necessary):

_____

If foods are listed to be omitted from diet, foods to substitute **MUST** be provided. *Note: New USDA guidance states juice is not a substitute for milk for students without disabilities.*

Foods to Omit	Allowed Substitutes

I certify that the above named student requires special dietary accommodations in accordance with the instructions indicated, as there exists a medical condition which makes administration advisable during school hours.

_____   _____   _____

Health Care Provider or Licensed Medical Authority Signature   *Date*   *Phone*

Health Care Provider or Licensed Medical Authority's Name (Print):_____

FOR SCHOOL USE ONLY

Date Kitchen Lead Received: _____   Date Copy Given to CNS Office: _____   Date Copy Given to School Nurse:_____

Updated: 08/21/2022