



Bremerton School District 100-C  
 Health Services Department  
 134 Marion Avenue North  
 Bremerton, WA 98312-3542  
 Office: 360-473-1073 Fax: 360-473-1043



## Diet Prescription for Meals at School

This document is in effect for the current school year and must be renewed annually

School: \_\_\_\_\_ Year: \_\_\_\_\_

**This section to be completed by PARENT / GUARDIAN:**

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

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

I give my permission for exchange of information between the School Nurse and Health Care Provider

\_\_\_\_\_  
*Parent / Guardian / Student Signature*

\_\_\_\_\_  
*Date*

**This section to be completed by HEALTH CARE PROVIDER or LICENSED MEDICAL AUTHORITY:**

Student Diagnosis: \_\_\_\_\_

Diet Prescription (Please attach additional instructions if necessary):

\_\_\_\_\_

Additional Information:

\_\_\_\_\_

\_\_\_\_\_

**Foods to Omit**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Foods to Substitute**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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*

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_