Jones County School District Child Nutrition
Diet Prescription for Meals at School

Student's Name: _ Date of Birth: _ Age:_________

Name of School:_____________________________Grade:____Homeroom Teacher: _______________________

Does your child have a Food Allergy or Medical condition that requires a special diet: Yes______No__________

If marked yes, please describe the Specific Food Allergy(ies) and/or Medical Condition:____________________
____

FOR PHYSICAN'S USE ONLY

Identify and describe the food(s) allergy or medical condition that requires the student to have a Special Diet.

____

____

List the Food or Foods to be **Omitted** from the child's diet: _

____

List the **Food or Choice** of Foods to be substituted: ____

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____

I certify that the above student needs a special school meal as described above due to the student's food allergy or chronic medical condition.

Physician's Signature: _ Date: __________________

I hereby give permission for the school staff to follow the above stated Nutrition Plan.

Parent/Guardian:____Date: __________________