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: _____

_____

_____

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:_____