

TUSCALOOSA CITY SCHOOLS

Diet Prescription

Student: _____ DOB: _____

School: _____ School

Year: _____

TO BE COMPLETED BY PHYSICIAN:

Student's diagnosis: _____

Describe the student's disability or major left activity affected by the disability:

Diet prescription: (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Limited Carbohydrates ("Carb. Counting") | <input type="checkbox"/> Increased Calorie |
| <input type="checkbox"/> Reduced Calorie | <input type="checkbox"/> Modified Texture |
| <input type="checkbox"/> _____ Calorie Diabetic Diet | <input type="checkbox"/> Other: _____ |

Food Restrictions: (Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Meat and meat alternatives | <input type="checkbox"/> Milk and milk products |
| <input type="checkbox"/> Bread and cereal products | <input type="checkbox"/> Fruits and vegetables |
| <input type="checkbox"/> Food Intolerance: _____ | |
| <input type="checkbox"/> FOOD ALLERGY: _____ | |

PLEASE LIST specific foods to be omitted and/or substitutions allowed on the back of this form or attach information.

Type or Textures allowed by mouth: (Check all that apply.)

- Solid Chopped Ground Mashed Pureed

Liquids (Thickened) Liquids (Un-thickened)

Other information: _____

Date of last swallow study (if applicable): ____/____/____

Physician signature

Date

Phone