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.)

☐ Limited Carbohydrates ("Carb. Counting") ☐ Increased Calorie

☐ Reduced Calorie ☐ Modified Texture

☐ _____Calorie Diabetic Diet ☐ Other:_____

Food Restrictions: (Check all that apply.)

☐ Meat and meat alternatives ☐ Milk and milk products

☐ Bread and cereal products ☐ Fruits and vegetables

☐ Food Intolerance:_____

☐ 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