Morgan County Schools Health Services

Diet Prescription for Meals At School

Child's Name ____ Birthdate _________________________

School ____ Grade ____________

Parent's Name ____ Contact Phone Number ______________

Disability or medical condition that restricts diet:

____

____

Major life activity affected by the disabled child:

____

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____

Foods to be Omitted	Foods to be Substituted

Please use the back of this form or attach additional list if needed

Diet prescription ____

____

____

Physician: ____ **Date** ________________

Phone: ___________________________