JEFFERSON PARISH SCHOOLS
Medical Statement to Request School Meal Modification
School Year 2024-2025

Meal service to students with special dietary needs is provided to all school sites. Federal and State regulations require a completed diet prescription form for any type of change or substitution to the student's diet. The special diet prescription form will need to be completed by your child's physician or medical authority and returned to your school cafeteria**.** Parents will need to provide any necessary meals for student until the form is processed. If you have questions regarding the form, please contact the Food Services Office at (504) 349 - 7768.

Student's Name: _____ Date of Birth: _____

PRESCRIBED DIET ORDER – *This part MUST be completed and signed by a medical authority as specified above.*

1. Specify the physical or mental impairment related to the prescribed diet order and describe the type of special diet/restriction required (i.e. food intolerance, food allergy, food restrictions due to a disease process):

2. Foods to be Omitted and Substituted: Check specific foods to be omitted and list approved substitutions below. If more space is needed, sign and attach additional sheet of paper. ☐ Check if not applicable

Dairy (please specify) ☐ Fluid Milk ☐ Cheese ☐ Yogurt ☐ All milk proteins (including dairy as an ingredient)

If fluid milk is to be restricted, check approved substitution ☐ Juice ☐ Water ☐ Lactose-Free Milk ☐ Soy Milk

Eggs (please specify) ☐ Whole eggs –hard boiled or scrambled **and/or** ☐ Egg as ingredient-albumin (white) & yolk

Other Allergens: ☐ Wheat ☐ Peanuts ☐ Tree Nuts ☐ Finfish ☐ Shellfish ☐ Soy*

***Soy Allergy:** Research states that *soy lecithin* and *soybean oil* is well tolerated by persons with soy allergy. If student avoids these ingredients please check here ☐

Specific food(s) to be omitted: (*please be as specific as possible)*	**Approved substitutions:**

3. **Calorie Count Allowed/Meal:** Breakfast _____ kcals Lunch _____ kcals ☐ Check if not applicable

4. **Carbohydrate Grams Allowed/Meal:** Breakfast _____ grams Lunch _____ grams
Snack (required/not required) AM _____ /PM_____ grams ☐ Check if not applicable

5. **Sodium Milligrams Allowed/Meal:** Breakfast _____ grams Lunch _____ grams ☐ Check if not applicable

6. **Total Fat Grams Allowed/Meal:** Breakfast _____ grams Lunch _____ grams ☐ Check if not applicable

7. **Modified Texture:**	☐ Chopped	☐ Ground	☐ Pureed	☐ Not Applicable
8. **Modified Thickness of Liquids:**	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick	☐ Not Applicable

9. **List Tube Feeding Formula:**
Number of Cans/Meal: Breakfast _____ can(s) Lunch _____ can(s) ☐ Check if not applicable

10**. List Special Feeding Equipment:** ☐ Check if not applicable

MEDICAL AUTHORITY'S CONTACT INFORMATION

Printed Name:	**Title:**
Office Address:	**Office Phone Number:**
Signature:	**Date:**

JEFFERSON PARISH SCHOOLS
Parent/Guardian Permission for Prescribed Diet Order
School Year 2024-2025

Student's Name:_____ Date of Birth:_____ School:_____

☐ **I give permission** for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals.

☐ **I give permission** for my child's medical authority to further clarify the prescribed diet order if requested to do so by school personnel.

☐ **I give permission** for my child to wear a visible identifier during the meal period in order to ensure that my child receives the prescribed diet order. **(ONLY FOR STUDENTS ATTENDING A SCHOOL PARTICIPATING IN THE CEP PROGRAM)**

Parent/Guardian's Name (Printed): _____

Parent/Guardian's Address: _____

Parent/Guardian's Phone: _____ Parent/Guardian's Email: _____

Parent/Guardian's Signature: _____ Date: _____