South Kitsap SCHOOL District No. 402

1962 HOOVER AVE. SE, PORT ORCHARD, WA 98366-3034 ● (360) 874-7000 ● FAX: (360) 874-7068

FORM 622

Diet Prescription for Meals at School

Student Name: ________________________ **Birth Date:** ____________ **School:** ______________ **Grade:** ______

Disability: ____

Major life activity affected: ____

or

Non-Disabling Medical Condition: ____

Diet Prescription: **(Check all that apply.)**

- ☐ Increased Calorie
  _____________________#kcal
- ☐ Diabetic
- ☐ PKU ____________________
- ☐ Food Allergy
- ☐ Other____________________

- ☐ Decreased Calorie
  _____________________#kcal
- ☐ Texture Modification:
  - ☐ Chopped
  - ☐ Ground
  - ☐ Pureed
  - ☐ Liquified
  - ☐ Tube Feeding
    - ☐ Liquified Meal
    - ☐ Formula ________ type

Foods to Omit:

____
____
____
____
____
____

Foods to Substitute:

____
____
____
____
____
____

Classroom Teacher:________________________ Homeroom Teachers:______________________

I certify that the above named student needs special school meals prepared as described above because of the student's disability of chronic medical condition.

____

Physician/Recognized Medical Authority Signature

Office Telephone: ____________________________ **Date:** ____________________________