Michigan City Area Schools
Opportunity ★ Excellence ★ Pride

Form # 526
Rev. 7/09

Office of Food Services
1100 S. Woodland Ave.
Michigan City, IN 46360
Phone: (219) 873-2131
Fax: (219) 873-2135
www.mcas.k12.in.us

Diet Prescription for Meals at School

Student's Name: ______________________________ School: ___________________________

Age: _______ Grade: _______ Parent/Guardian: ___________________________________

Disability: ________________ **OR** Non-Disabling Medical Condition: __________________

Major Life Activity Affected: ____

Diet Prescription (check all that apply):

- ❑ Increased Calories
- ❑ Decreased Calories
- ❑ Diabetic
- ❑ Food Allergy: __________________________
- ❑ Other: ________________________________
- ❑ Texture Modification
- ❑ Chopped
- ❑ Ground
- ❑ Pureed

Foods to Omit:

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____

Foods to Substitute:

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

____
Physician/Recognized Medical Authority Signature

Office Phone Number: _________________________ Date: ____________________