



Office of Food Services
1100 S. Woodland Ave.
Michigan City, IN 46360
(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):

- | | |
|--|---|
| <input type="checkbox"/> Increased calories | <input type="checkbox"/> Texture Modification |
| <input type="checkbox"/> Decreased calories | <input type="checkbox"/> Chopped |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Ground |
| <input type="checkbox"/> Food Allergy: _____ | <input type="checkbox"/> Pureed |
| <input type="checkbox"/> Other: | |

Foods to Omit:

Foods to Substitute:

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: _____