Snohomish County Early Childhood Education and Assistance Program

Snohomish County Human Services Department

Diet Prescription for Meals At School

Child's Name _____ Date of Birth _____

Name of Parent _____ Phone _____ _____
Day Number Evening Number

ECEAP or School Program _____

Special needs or medical conditions: _____

☐ Food Allergy or Food Intolerance

Note: If your child has a food or milk allergy, we must have documentation of the allergy from your medical care provider or doctor. <u>For milk allergies or intolerance, the doctor must also name a substitute for the milk</u>.

List Each Food Separately	Briefly describe child's reaction and/or check symptoms	List appropriate substitute food(s)
	☐Hives ☐Wheezing ☐Runny Nose ☐Shortness of Breath	
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	☐Hives ☐Wheezing ☐Runny Nose ☐Shortness of Breath	
	☐Hives ☐Wheezing ☐Runny Nose ☐Shortness of Breath	

Other Diet Prescription (Check all that apply)

☐ PKU

☐ Other _____

Texture Modification
- ¨ chopped
- ¨ ground
- ¨ pureed
- ¨ liquefied

Tube Feeding
- ¨ liquified meal
- ¨ formula _____type

Supplement
- ¨ _____

Foods to Omit

_____
_____
_____

Foods to Substitute

_____
_____
_____

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

_____ _____ _____

Physician or Recognized Medical Authority Signature Office Phone Number Date

Mailing Address

(Adapted from OSPI Child Nutrition Programs and Seattle-King County Department of Public Health Child Care Health Program)