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STATE OF NEW HAMPSHIRE
DEPARTMENT OF EDUCATION
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SPECIAL MEALS PRESCRIPTION CHILD NUTRITION PROGRAMS

NAME OF STUDENT: _____

DOB: _____ SPEDIS ID NO: _____

SCHOOL NAME: _____

Is student Disabled Nondisabled

Disability or medical condition that requires the student to have a special diet. Include a brief description of the major life activity affected by the student's disability.

Diet Prescription (Check all that apply)

- Diabetic Reduced Calorie
- Increased Calorie Modified Texture
- Other (describe) _____

Foods Omitted and Substitutions (Please check food groups to be omitted. List specific foods to be omitted and substitutions to be included using the back of this form or attach information.)

- Meat and Meat Alternates Milk and Milk Products
- Bread and Cereal Products Fruits and Vegetables

Textures Allowed (Check the allowed textures.)

- Regular Chopped Ground Pureed None

Other Information Regarding Diet or Feeding (Please provide additional information on the back of this form or attach to this form.)

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's Signature Office Phone Number Date

Typed Name: _____ Oral Motor Specialist / Nutritionist

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