



STATE OF NEW HAMPSHIRE
DEPARTMENT OF EDUCATION

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EQUAL OPPORTUNITY EMPLOYER-EQUAL EDUCATION OPPORTUNITIES

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Commissioner
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**SPECIAL MEALS PRESCRIPTION
CHILD NUTRITION PROGRAMS**

NAME OF STUDENT: _____ DOB: _____

SPEDIS ID NO: _____ SCHOOL NAME: _____

Is student: Disabled Nondisabled (please check appropriate box.)

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/Feeding Prescription (check all that apply) Diabetic Reduced Calorie Increased Calorie Modified Texture
Other: (describe) _____

Foods Omitted and Substitutions
(check all that apply)

I. Breads, Grains, Cereal	Omit	Food Preparation for Texture	Substitution
_____ Bread/Rolls	_____	_____	_____
_____ Pasta	_____	_____	_____
_____ Rice	_____	_____	_____
_____ Waffles/French Toast/Pancakes	_____	_____	_____
_____ Taco Shells	_____	_____	_____
_____ Soft Tortillas	_____	_____	_____
_____ Crackers	_____	_____	_____
_____ Cereals	_____	_____	_____
_____ Other	_____	_____	_____

II. Fruits and Vegetables	Omit	Food Preparation for Texture	Substitution
_____ Raw:	_____	_____	_____
_____ Canned:	_____	_____	_____
_____ Potato:	_____	_____	_____
_____ Other:	_____	_____	_____

III. Milk/Dairy Products	Omit	Food Preparation for Texture	Substitution
_____ Milk:	_____	_____	_____
_____ Yogurt:	_____	_____	_____
_____ Cheese:	_____	_____	_____
_____ IceCream/Frozen Desserts	_____	_____	_____
_____ Other:	_____	_____	_____

IV. Meats/Protein Foods	Omit	Food Preparation for Texture	Substitution
_____ Meats	_____	_____	_____
_____ Nuts/Seeds	_____	_____	_____
_____ Eggs:	_____	_____	_____
_____ Canned/Dried Beans:	_____	_____	_____
_____ Other:	_____	_____	_____

V. Fats/ Sweeteners/ Sauces	Omit	Food Preparation for Texture	Substitution
_____ Sauces/Dressings:	_____	_____	_____
_____ Spreads:	_____	_____	_____
_____ Other:	_____	_____	_____

VI. Desserts	Omit	Food Preparation for Texture	Substitution
_____ Cakes:	_____	_____	_____
_____ Cookies	_____	_____	_____
_____ Puddings/Whips:	_____	_____	_____
_____ Jello:	_____	_____	_____
_____ Other:	_____	_____	_____

VII. Combination Foods	Omit	Food Preparation for Texture	Substitution
_____ Soups:	_____	_____	_____
_____ Lasagna, Chop Suey, Spaghetti	_____	_____	_____
_____ Pizza:	_____	_____	_____
_____ Other:	_____	_____	_____

VIII. Liquids

_____ Thickened Consistency: syrup nectar honey

_____ Thickeners: _____

_____ No Liquids Offered

_____ Special Feeding Utensils/Equipment: _____

IX. Other Information Regarding Diet (for SPED team)

_____ Safe Eating Plan In Place (See Modification Section of Individual Education Plan (IEP))

_____ Stop Feeding When _____

_____ Record: _____

_____ Other: _____

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
_____	_____		
Nutritionist	Feeding and Swallowing Specialist		

Circle appropriate copy recipients