



STATE OF NEW HAMPSHIRE
DEPARTMENT OF EDUCATION

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EQUAL OPPORTUNITY EMPLOYER-EQUAL EDUCATION OPPORTUNITIES

Lyonel B. Tracy
Commissioner
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Deputy Commissioner
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SPECIAL MEALS PRESCRIPTION
CHILD NUTRITION PROGRAMS

NAME OF PARTICIPANT: _____ DOB: _____

ID NO: _____ INSTITUTION NAME: _____

Is participant: Disabled [] Nondisabled [] (please check appropriate box.)

Disability or medical condition that requires the participant 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)

Table with 4 columns: Food Category, Omit, Food Preparation for Texture, Substitution. Rows include I. Breads, Grains, Cereal; II. Fruits and Vegetables; III. Milk/Dairy Products.

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 participant needs special meals prepared as described above because of the participant's disability or chronic medical condition.

_____	_____	_____	_____
Physician's Signature	Office Phone Number	Date	Typed Name

_____	_____
Nutritionist	Feeding and Swallowing Specialist

Circle appropriate copy recipients