SCHOOL HEALTH SERVICES

PRESCRIPTION DIET FORM
(PHYSICIAN'S SIGNATURE REQUIRED)

Requires renewal at the beginning of each school year

Name of Student _____ D.O.B._____

Address _____ Telephone _____

Parent/Guardian Name _____ School _____

To be completed by medical staff:

Condition: _____

Diet Accommodation needed: _____

_____ _____ _____

Physician's Signature Telephone Date

_____ _____

PRINT Physician's Name Clinic Name

(Changes may be called to the school nurse by the prescribing provider with written confirmation following within 24 hours. Faxes are acceptable.)

Parent/Guardian Signature _____ Date _____

Reviewed: AAllison, RNC: 2/2024