

# Legacy Preparatory Academy

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Principal  
Ms. Yolonda Capers

[www.legacyprepacademy.org](http://www.legacyprepacademy.org)

302 E. Linebaugh Avenue  
Tampa, Florida 33612  
Ph: (813) 253-0053  
Fax: (813) 253-0182

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Dear Parent/Legal Guardian,

The Student Nutrition Services Department strives each day to offer healthy well-balanced meals to our students. Meals are **free** to **all** students.

To accommodate students that may have special dietary needs due to handicaps, disabilities and/or food allergies, including, but not limited to wheat, eggs, soy, fish, shellfish, milk, peanuts and other tree nuts, the Student Nutrition Manager can make substitutions in meal choices. In order for the manager to make any changes, we must have a completed **Diet Prescription for Special Meals** form (see attached). Simply complete the form with a signature by the student's physician or attached a signed physician's prescription form and return to the school. Once the form is **returned** with physician's signature, the substitutions/modifications necessary to accommodate the student will be made. One form per student must be completed for each school year.

Attachment

*Diet Prescription for Special Meals Form*

# Legacy Preparatory Academy

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## DIET PRESCRIPTION FOR SPECIAL MEALS FORM SCHOOL YEAR 2017-2018

Please complete the form and return to Legacy Preparatory Academy.

**Physician's signature is required**

Name of Student \_\_\_\_\_ Student's Age \_\_\_\_\_ Grade \_\_\_\_\_  
(please print)

### Section A

Does the student have a disability? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe the major life activities affected by the disability.

If yes, does the student have special nutritional or feeding needs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, complete Section C and Section D

(Completion of this section will require a meeting between the parent, the Student Nutrition Manager and the School Nurse)

### Section B

If the student does not have a disability, does he/she have special nutritional or feeding needs? Yes \_\_\_\_ No \_\_\_\_

If yes, complete Section C and Section D

### Section C

Provide the diet prescription: (attach a list of foods to be omitted and/or substituted, if needed)

List foods that need to be modified in texture. If all foods need to be prepared in this manner, indicate "all".

Chopped \_\_\_\_\_

Ground \_\_\_\_\_

Pureed \_\_\_\_\_

Add any other comments regarding the student's eating or feeding patterns.

List any food allergies to avoid.

### Section D

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

I certify that the above named student needs special school food as described above,

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Office Number

\_\_\_\_\_  
Date

For School Use Only

Date Entered \_\_\_\_\_  
(From must be maintained on file for the current school year)

Manager's Signature \_\_\_\_\_