Legacy Preparatory Academy

Principal
Dr. Yolonda Capers

www.legacyprepacademy.org

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

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

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DIET PRESCRIPTION FOR SPECIAL MEALS FORM
SCHOOL YEAR 2019-2020

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 _____ Manager's Signature _____
(From must be maintained on file for the current school year)