Parma City Schools Nutrition Services Department

Physician's Order for
Therapeutic Diet/Food Allergies

Student's Name: _____School/Grade: _____School Year: _____

Diet Related Diagnosis: _____

Is this a disability? Yes _____ No_____

Is this a life-threatening allergy? Yes_____ No_____

Diet Prescription: _____

Foods to be omitted: _____

_____

Foods to be substituted: _____

_____

Has the patient received a written diet instruction? Yes No

Please attach a copy of the diet instruction.

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____

Clinic Location: _____ Telephone Number: _____

_____

_____

PLEASE RETURN THIS COMPLETED FORM to:

Robert Gorman
Nutrition Services Department
5311 Longwood Avenue
Parma, OH 44134

OR FAX to: 440-885-3768

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