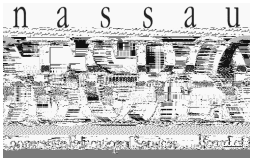

Physician's Diet Prescription

Student Name _____ DOB_____ Date _____

To Be Completed by Physician:

Diagnosis_____
Allergies_____

Regular Diet (All textures) and **All Liquids** (No modifications)

OR

Modified: Please indicate appropriate modification needed for **liquid, diet or both.**

LIQUID (CHECK ONE)	**DIET (CHECK ONE)**
Regular Liquids (Not modified e.g. Milk or Juice)	Regular Diet (Not modified)
Thickened Liquids (Nectar)	Soft Diet (No fried foods)
Thickened Liquids (Honey)	! inch Chopped Diet (regular food chopped into ! inch pieces)
	Ground Diet (tuna salad, chicken salad, casserole)
	Pureed Diet (pudding, mashed potatoes)

Allowed to advance diet as tolerated. Please list foods allowed or not allowed.

FOODS ALLOWED:	**FOODS NOT ALLOWED:**

Physicians Signature: _____ Date: _____
Address: _____ Phone: _____
Stamp: License #: _____

Return to: _____ Phone: _____
Fax: _____