nassau BOCES
Board of Cooperative Educational Services

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)	☐ ¼ inch Chopped Diet (regular food chopped into ¼ 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: _____