

School Year 2019-2020
Diet Modifications for Meals at School for Children with a
Diagnosed Food Allergy, Lactose Intolerance or Other Disability Affected by Diet

Name of Student: _____ School Attending: _____ Student ID # _____

All students are welcome and encouraged to participate in the school meal program. If your student has special dietary needs due to a diagnosed medical condition and wishes to participate in the meal program, this form must be completed by your licensed health care provider and returned to the school nurse so menu adjustments can be made. This information will be annotated on your student's meal account to help ensure their needs are met and will be kept on file until such time that it is modified or discontinued in writing by a licensed health care provider.

Dietary information is to be completed by student's licensed health care provider ONLY.

LACTOSE INTOLERANCE SECTION

Diagnosis of Lactose *Intolerance* AVOID:

Liquid Milk Cheese Ice Cream Yogurt All Milk, Even Trace Amounts

LIFE-THREATENING FOOD ALLERGY/DISABILITY SECTION

Diagnosis of Disability or Life-Threatening Food Allergy that requires the student to have a diet modification:

Include a brief description of the major life activity affected by the student's condition: _____

Please check food(s) to be OMITTED.

Milk/Dairy Products _____ Soy/Soy Products _____
 Eggs/Egg Products _____ Wheat/Wheat Products _____
 Peanuts _____ Tree Nuts _____
 Fish _____ Shellfish _____
 Other _____

Please list additional information or suggested substitutions here: _____

MODIFIED TEXTURE SECTION

Food Consistency: Regular Chopped Ground Pureed
Liquid Consistency: Thin Nectar Honey Pudding

I certify that the above-named student needs diet modifications as described above because of the student's disability, life-threatening food allergy or lactose intolerance:

Licensed Physician's Signature

Office Phone

Date

Printed Physician's Name

I understand that if my child's medical needs change, it is my responsibility to notify the school and to provide an updated Diet Modification Form completed by a licensed health care provider. I give my permission to share the information on this form with the individuals who take part in the care of my child during the school day and understand that the doctor's office may be contacted when additional clarification is needed.

Parent's/Guardian's Signature

Phone Number

Date