School Year 2020-2021
Diet Modifications for Meals at School for Children with a Diagnosed Food Allergy, Other Disability or Lactose Intolerance

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 that 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 the 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 ( ) 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**

Adapted from the Handbook for Children with Special Food & Nutrition Needs – NFSMI Item #ET69-06
In accordance with the Maryland State Department of Education Management and Operations Memorandum #16 (4/00)
CC: □School Nurse □School Cafeteria Manager □Child Nutrition Office