

<insert District Name>

MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

Please return completed and signed form to <INSERT STAFF NAME, EMAIL, DROP OFF LOCATION>

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (Last, First): _____ Grade: _____

School: _____

Parent/Guardian Email: _____ Daytime Phone: _____

Based on information listed below my child will require a menu modification at the following: Breakfast Lunch Afterschool Snack

Supper Other _____

I understand it is my responsibility to renew this form each school year and/ or any time my child's medical or health needs change.

Parent/Guardian Name PRINTED

Parent/Guardian SIGNATURE

Date

TO BE COMPLETED BY MEDICAL AUTHORITY (Licensed by State of Illinois to prescribe medication)

The Dietary Needs below are related to (ex: Celiac Disease, Lactose Intolerance, Diabetes, Anaphylactic Food Allergy)

Food To BE OMITTED from diet* (check appropriate boxes below)

- Dairy** – Fluid milk, cheese, yogurt, and other dairy ingredients such as casein and whey.
- Fluid Milk** – Milk to drink
- Peanuts** – Peanuts, Peanut Butter, Peanut oil.
- Tree Nuts** – Almonds, hazelnuts, and cashews.
- Wheat** – Wheat-based grains such as buns, crackers, pasta, and wheat as an ingredient.
- Gluten** – Wheat, rye, barley, and non-certified oats.
- Fish** – Fin-fish such as cod and tilapia
- Shellfish** – Shrimp and crab
- Egg** – Visible egg in a dish such as an omelet
- Egg Ingredients** – Egg white, egg yolk or whole egg as an ingredient
- Soybean** – Textured Soy Protein, Textured Vegetable Protein, tofu, and whole soybeans (edamame).
- Soybean Ingredients** – Soy protein concentrate, soy protein isolate, soy sauce, soy flour, and unrefined soy bean oil
- Other** - _____

*Examples of individual food allergens provided are not all-inclusive, other foods may apply.

Adjustment to meal preparation (i.e. food puree) and /or serving time(s):

Food Management Plan

What are the student's possible reactions/symptoms to the indicated allergen(s) or conditions?

REQUIRED List all acceptable and safe food or beverage substitutes:

Comments: _____

Prescribing Physician/Medical Authority Name Printed

Date

Prescribing Physician/Medical Authority Signature

FOR FOOD SERVICE NOTES (Other information, please see back)

Date Received: _____ By: (employee signature)

Date Implemented: _____ By: (employee signature)

Other information: _____