Olentangy Local Schools
Food Allergy/Disability/Special Dietary Needs Form for Diet Modification or Substitution

The USDA School Meals Program requires that all questions be answered in order for any diet modification or substitution to be made in schools meals. Please complete and return to your school cafeteria.

Part A: General Information: To Be Completed by Parent/Guardian

Student Name: _____ Date of Birth: _____Student ID#_____
School: _____Grade: _____
Parent/Guardian: _____ Cell phone: _____
Address: _____ Home phone: _____

Part B: Life Threatening Food Allergy Medical Professional Statement: To Be Completed by a Medical Professional (If there is no life threatening food allergy, skip this section and go to Part C)

I declare the student listed above to possess a Life Threatening Food Allergy. _____
Medical Professional's name (printed)

1. Life threatening food allergy – circle all foods that must be omitted:
   Milk Peanut Tree Nut Egg Fish Shellfish Wheat Soy
   Other life threatening food allergy, please specify_____
2. Can the student consume foods where the allergen is an ingredient in the food product? ___YES ___NO
   (Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)
   Additional detail _____
3. Explanation of why this disability restricts diet: _____
4. Major life activity affected by the life threatening food allergy (check all that apply) :
   ___ eating ____ caring for oneself ____ performing manual tasks ____walking
   ___ hearing ____ speaking ____ breathing ____learning
   ___ seeing ____ operation of major bodily function (immune system, bowl, digestive, brain, etc.)
   ___Other, specify _____
5. Foods to substitute:
   _____
   _____

Medical Professional's Signature: _____Date: _____
Clinic/Facility Name & Address: _____ Telephone: _____

Part C: Disability Medical Professional Statement: To be Completed by a Medical Professional
(If there is no disability, skip this section and go to Part D)

I declare the student listed above to possess a Disability. _____
Medical Professional's name (printed)

1. Circle all disabilities requiring meal modification:

Autism	Cancer/leukemia	Drug addiction/alcoholism
Cerebral palsy	Traumatic brain injury	Metabolic disease,
Epilepsy	Orthopedic impairment	specify_____
Speech impairment	Intellectual Disability	Hemophilia
Visual impairment	Heart disease	Rheumatic fever
Hearing impairment	HIV	Nephritis
Muscular dystrophy	Tuberculosis	Specific learning
Multiple sclerosis	Emotional Disturbance	disabilities

Part C Continued:

2. Explanation of why this disability restricts diet: _____
3. Major life activity affected by the life threatening food allergy (check all that apply) :
   ___ eating ____ caring for oneself ____ performing manual tasks ____walking
   ___ hearing ____ speaking ____ breathing ____learning
   ___ seeing ____ operation of major bodily function (immune system, bowl, digestive, brain, etc.)
   ___Other, specify _____
4. Foods to omit:
   _____
   _____
5. Foods to substitute:
   _____
   _____

Medical Professional's Signature: _____Date: _____
Clinic/Facility Name & Address: _____ Telephone: _____

Part D: Other Medical or Special Dietary Needs Medical Professional Statement: To be Completed by a Medical Professional

I declare the child listed above to possess a medical or special dietary need. _____
Medical Professional's name (printed)

1. Specify the medical or special dietary condition: _____
2. Foods to omit:
   _____
   _____
3. Foods to substitute:
   _____
   _____

Medical Professional's Signature: _____Date: _____
Clinic/Facility Name & Address: _____Telephone: _____

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Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.