Food Allergy Notification and Modification Request Form

*This form is to be completed by a licensed physician (or other medical authority) or parent/guardian for **students who have been diagnosed with a life threatening food allergy or a disability and require a special diet or food accommodation**. Please note, an individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as well as the USDA's nondiscrimination regulation, as a person who has physical or mental impairment that substantially limits one or more major life activities and that all reasonable requests for food and beverage substitutions will be made so the student can eat.*

****** In order to best and safely accommodate students, this form should be filled out in its ENTIRETY and be turned into the school nurse within five (5) school days. Forms that are not filled out entirely and accurately can potentially cause unnecessary dietary restriction or inaccurate accommodation.******

PART I - Parent/Legal Guardian to complete this section: **Student Grade:** _____ **Student ID#** _____ **Sex:** M F

Student Last Name _____ Student First Name _____ School Building _____

Parent/Legal Guardian Name (s) _____ Phone # _____

Parent/Legal Guardian Name (s) _____ Phone # _____

Parent/Legal Guardian Email Address: _____

Which of the above is the best way to contact parent/guardian with questions? Phone Email

PART II – Parent/Legal Guardian OR Licensed Physician to complete this section:

Please check all FOODS that apply to be avoided by this student to prevent a life-threatening reaction:

☐ Fluid Milk ONLY ☐ Dairy (Ex: Yogurt, Cheese) ☐ Baked-in Dairy (Ex: Cookies, Bread, Gravy)	☐ Eggs (Ex: Scrambled, Boiled) ☐ Baked-in Eggs (Ex: Cookies, French Toast)
☐ Wheat	☐ Peanuts
☐ Soy	☐ Tree nuts
☐ Fish	☐ Shellfish
☐ Other- Please Specify:	
☐ **Check this box if an EpiPen is prescribed for any of the above.** **Please Specify Foods:** _____.	
Please list the appropriate foods (if any) to substitute for the allergen-containing foods listed above:	

Please see reverse side in order to complete form.

PART III – Parent/Legal Guardian OR Licensed Physician to complete this section:	
Student's Disability:	
Brief explanation of why the disability restricts the student's diet:	
Please identify the major life activity affected by the disability:	
Physician Signature:	Date Signed:
Printed Name of Physician:	Doctor's Office Phone #:

PARENTAL CONSENT: By signing this form, I consent to the sharing of this information with appropriate district staff (this includes but is not limited to administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches and substitute employees). I also agree TO THE FOLLOWING: Notify the school if the food allergy or epinephrine prescription is changed or discontinued; Grant permission for the school nurse to confer with the doctor regarding health and treatment issues as they pertain to the above medications and or diagnosis as related to his/her educational and behavioral management needs; Provide safe transportation of the medication to and from school to a school official and to provide a back-up dose of Epinephrine (if medical authorization is given per Ohio Revised Code 3313.718).
By signing this form, I also acknowledge that falsifying or inaccurately reporting any of the information on this form can result in delayed or inaccurate accommodation, unnecessary restriction of diet, and potential danger to my child. The TSC shall not be held liable for any harm caused by inaccurate reporting by legal guardian or Licensed Physician on this form.

Signature of Parent/Guardian:	Date:

School/Faculty Use Only:

- ☐ Form Received on _____.
- ☐ Form incomplete. Parent contacted on _____.
- ☐ Form complete. Accommodation will not be made.
  - ☐ Request not reasonable
  - ☐ Lifestyle or Religious accommodation not required by law.
- ☐ Accommodations within meal pattern.
- ☐ Accommodations NOT within meal pattern.
- ☐ Accommodations will begin on _____.
- ☐ 504 Coordinator Contacted.
- ☐ Doctor's note on file.

Signed: _____

Printed: _____ Date: _____