



Student Name: _____ Date of Birth ____/____/____

**Parent Request for School Meal
Accommodation and Physician's Prescription
for Food Allergy**

Student Name: _____ Student ID Number: _____ Date: ____/____/____

USDA regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities (including allergic reactions) restrict their diets. A child with a disability will be provided substitutions in foods when supported by a statement signed by a licensed physician. The statement must identify: the child's disability, an explanation of why the disability restricts the child's diet, the major life activity affected by the disability, and the food(s) that must be omitted and/or substituted from the child's diet. Accommodations will be initiated upon receipt of physician directions on this modified school lunch form.

Signing below consents to communication between school health professionals and the physician regarding the student listed above.

Signature of Parent/Guardian _____ Phone Number(s) _____

MEDICAL DIAGNOSIS: _____

LENGTH OF DIETARY RESTRICTION:

☐ Temporary until _____

☐ Life Long

WEIGHT REDUCTION DIET

- ☐ Calorie Restriction: _____ calories/meal
- ☐ Substitute Fruit for any Dessert
- ☐ Skim Milk Only

WEIGHT INCREASE DIET

- ☐ Calorie Goal: _____ calories/meal
- ☐ High Protein: _____ g Protein/meal
- ☐ High CHO Diet: _____ g CHO/meal

DIABETIC DIET

- ☐ _____ grams CHO at Breakfast
- ☐ _____ grams CHO at Lunch

- ☐ _____ grams CHO at Snack
- ☐ No restriction

RENAL DIET

- ☐ _____ gram Sodium restriction
- ☐ _____ gram Potassium restriction

- ☐ _____ gram Phosphorus restriction
- ☐ _____ gram Protein allowed

CARDIAC DIET

- ☐ _____ gram Sodium restriction
- ☐ _____ gram Fat restriction

☐ Other: _____

TEXTURE MODIFICATION

- ☐ Chopped or Bite sized foods
- ☐ Pureed
- ☐ Thickened Liquid to _____ Consistency.
(use _____ teaspoon(s) of thickener per oz liquid)

OTHER NEEDS

- ☐ Fiber Additives (provided by parent)
- ☐ MCT Oil or Other Caloric Enhancer (provided by parent)
- ☐ Meal replacements (prescription including formula, dosage and time must be provided)

FOOD ALLERGIES

Type of Allergic Reaction:

- | | | |
|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Rash/Hives | <input type="checkbox"/> Stomach Discomfort | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swelling | |

Below are the most common allergies. Please check the appropriate boxes. Use the "OTHER" section to include any food allergies not listed. Do not rely on a list of prepackaged foods. Ingredients can change often and without notice.

EGGS <i>(please check one)</i>	<input type="checkbox"/> Allowed in Cooking <input type="checkbox"/> Not Allowed in Cooking		
MILK:	<i>Please check one:</i> <input type="checkbox"/> Lactose Intolerance <i>(student will be given the option of lactose free milk)</i> <input type="checkbox"/> Milk Allergy <i>(student will be given the option of 100% juice or water unless otherwise noted)</i>		
	<i>Please check one:</i> <input type="checkbox"/> Avoid fluid milk only <input type="checkbox"/> Milk allowed in cooking <i>(excludes dairy products such as cheese, yogurt, etc.)</i> <input type="checkbox"/> Milk not allowed in cooking		
CORN <i>(check all that apply)</i>	<input type="checkbox"/> Avoid whole kernels only <input type="checkbox"/> Avoid corn protein <input type="checkbox"/> Avoid corn derivatives <i>(includes food starch, modified food starch, cornmeal, grits, corn flours, corn starch, corn syrup, corn syrup solids, vegetable starch, vegetable gum, baking powder)</i>		
FISH/SHELLFISH <i>(check all that apply)</i>	<input type="checkbox"/> Avoid fish <input type="checkbox"/> Avoid shellfish <input type="checkbox"/> Avoid area when cooking		
PEANUTS <i>(check all that apply)</i>	<input type="checkbox"/> Ingestion <input type="checkbox"/> Touch <i>(student will be offered alternative seating within the cafeteria)</i> <input type="checkbox"/> Inhalation* <i>(student will be offered an alternative location outside of the cafeteria)</i>		
TREE NUTS <i>(check all that apply)</i>	<input type="checkbox"/> Ingestion <input type="checkbox"/> Touch <i>(student will be offered alternative seating within the cafeteria)</i> <input type="checkbox"/> Inhalation* <i>(student will be offered an alternative location outside of the cafeteria)</i>		
<small>*Inhalation protocols include removing the child from the lunch room. This precaution is due to the fact that we cannot guarantee what another student brings from home. Please use with appropriate discretion.</small>			
WHEAT:	<input type="checkbox"/> Avoid globulins <input type="checkbox"/> Avoid albumins <input type="checkbox"/> Avoid gliadins <input type="checkbox"/> Avoid glutenins		
GLUTEN:	<input type="checkbox"/> Avoid wheat <input type="checkbox"/> Avoid barley <input type="checkbox"/> Avoid rye <input type="checkbox"/> Avoid oats		
SOY:	<input type="checkbox"/> Avoid soy protein <input type="checkbox"/> Avoid soy byproducts <input type="checkbox"/> Avoid soybean oil <i>(Soybean oil may not be listed as an allergen as it is highly refined and often unlikely to cause a reaction)</i>		
OTHER:	<input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____

Additional Notes: _____

Physician's Name: _____ Physician's Signature: _____

Address: _____ Phone Number: _____

Student Name: _____ Date of Birth ____/____/____

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(1) mail: U.S. Department of Agriculture
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.

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