

**Gahanna-Jefferson Schools**  
**Child Nutrition and Food Services Department**

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**School Meals**  
**Food Allergies, Special Diets and Restrictions Form**

The USDA School Meals Program requires that ***all questions*** be answered in order for any diet modification or substitution to be made in school meals. Please complete along with your medical professional.

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

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student ID# \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Part B: Life Threatening Food Allergy Medical Professional Statement:  
To Be Completed by Medical Professional**

**(If there is NO life threatening food allergy(s), please skip this section and go to Part C-on back).**

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 that must be omitted:

Milk    Wheat    Egg    Soy    Peanut    Tree Nut    Fish    Shellfish

Other life threatening food allergy, please specify \_\_\_\_\_

2. Can the student consume food where the allergen is an ingredient in the food product? \_\_\_YES \_\_\_NO

(Example: scrambled eggs are omitted but egg as an ingredient in pancake is allowed)

Additional Detail: \_\_\_\_\_

Explanation of why this disability restricts diet: \_\_\_\_\_

3. Major life activity affected by the life threatening food allergy (check all that apply):

\_\_\_breathing    \_\_\_operation of major bodily function (immune system, bowel, digestive, etc.)

\_\_\_ Other, specify \_\_\_\_\_

4. FOODS TO SUBSTITUTE: (If a student cannot drink milk, water with cups are available at every school.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic/Facility Name and Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Part C: Other Medical or Special Dietary Needs Medical Professional Statement: To be Completed by a Medical Professional (If your child requires a school meal restriction with no substitution, please skip to Part D)**

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: (If a student cannot drink milk, water with cups are available at every school.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medical Professional's Signature: \_\_\_\_\_  
 Clinic/Facility Name and Address  
 \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

The USDA nondiscrimination regulation (7 CFR 15 b) as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to regular meals must be made for children who are UNABLE to eat school meals because of their disabilities, when the need is certified by a medical professional.

OFFICE USE Copies to: \_\_\_\_\_ Nurse \_\_\_\_\_ Food Service Office \_\_\_\_\_ Cafeteria(Alert)

**Part D: Dietary Restrictions(Non-Allergy) - Check all that should be omitted from school meals by your student: To be completed by Parent/Guardian**

\_\_\_ Liquid Milk (water with cups are available at all schools) \_\_\_ Wheat \_\_\_ Whole Eggs  
 \_\_\_ Foods with eggs baked in \_\_\_ Soy \_\_\_ Peanuts \_\_\_ Tree Nuts \_\_\_ Fish \_\_\_ Shell Fish  
 \_\_\_ Dairy Products (cheese, yogurt, ice cream, sour cream)  
 \_\_\_ Pork \_\_\_ Pork Gelatin \_\_\_ Vegetarian  
 \_\_\_ Other (please specify)

**Part E: School Meal Purchasing Restrictions -To be completed by Parent/Guardian:** (Ex, May purchase plate lunch only, May purchase snacks with cash only, etc)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Please return this form to your student's school or mail to Gahanna Jefferson Schools Child Nutrition and Food Services Department, 160 S Hamilton Road, Gahanna, OH 43230.*