

# Gahanna-Jefferson Schools Food Services

## Food Allergy/Disability/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 school 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: \_\_\_\_\_ 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:(Required Answer)\*

Milk Wheat Egg Soy Peanut Tree Nut Fish Shellfish Sesame Dairy Products

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)

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 (Required answer) \* \_\_\_\_\_

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

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

**Part C: Other Medical or Special Dietary Needs Medical Professional Statement: NON-LIFE THREATENING. 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: REQUIRED ANSWER\*  
\_\_\_\_\_  
\_\_\_\_\_

3. Foods to substitute: REQUIRED ANSWER\*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**Clinic/Facility Name and Address** \_\_\_\_\_

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

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

- Liquid Milk     Wheat     Whole Eggs  
 Foods with eggs baked in     Soy     Peanuts     Tree Nuts     Fish     Shell Fish     Sesame  
 Dairy Products (cheese, yogurt, ice cream, sour cream)  
 Pork  
 Other (please specify)

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.

This institution is an equal opportunity provider