

**MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM**

Please return, completed, and signed, form to your child’s school.

**TO BE COMPLETED BY PARENT OR GUARDIAN**

Name of Student (Last, First): \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Based on information listed below my child will require a menu modification at the following:  Breakfast  Lunch  Afterschool Snack  
 Supper  Other \_\_\_\_\_

**I understand it is my responsibility to renew this form each school year and/ or any time my child’s medical or health needs change.**

Parent/Guardian Name PRINTED

Parent/Guardian SIGNATURE

Date

**TO BE COMPLETED BY MEDICAL AUTHORITY (Licensed by State of Illinois to prescribe medication)**

The Dietary Needs below are related to (ex: Celiac Disease, Lactose Intolerance, Diabetes, Anaphylactic Food Allergy)

Food To BE OMITTED from diet\* (check appropriate boxes below)

- Dairy – Fluid milk, cheese, yogurt, and other dairy ingredients such as casein and whey.
- Fluid Milk – Milk to drink
- Peanuts – Peanuts, Peanut Butter, Peanut oil.
- Tree Nuts – Almonds, hazelnuts, and cashews.
- Wheat – Wheat-based grains such as buns, crackers, pasta, and wheat as an ingredient.
- Gluten – Wheat, rye, barley, and non-certified oats.
- Fish – Fin-fish such as cod and tilapia
- Shellfish – Shrimp and crab
- Egg – Visible egg in a dish such as an omelet
- Egg Ingredients – Egg white, egg yolk or whole egg as an ingredient
- Soybean – Textured Soy Protein, Textured Vegetable Protein, tofu, and whole soybeans (edamame).
- Soybean Ingredients – Soy protein concentrate, soy protein isolate, soy sauce, soy flour, and unrefined soybean oil
- Other - \_\_\_\_\_

\*Examples of individual food allergens provided are not all-inclusive, other foods may apply.

Adjustment to meal preparation (i.e. food puree) and /or serving time(s):

**Food Management Plan**

What are the student’s possible reactions/symptoms to the indicated allergen(s) or conditions?

**REQUIRED** List all acceptable and safe food or beverage substitutes:

Comments: \_\_\_\_\_

Prescribing Physician/Medical Authority Name Printed

Date

Prescribing Physician/Medical Authority Signature

**FOR FOOD SERVICE NOTES (Other information, please see back)**

Date Received: \_\_\_\_\_ By: (employee signature)

Date Implemented: \_\_\_\_\_ By: (employee signature)

Other information: \_\_\_\_\_