Return completed form to:
Email: CClarahan@cps.k12.in.us
OR
Mail to: Food Service; 1050 S. Main Street, Crown Point, IN 46307

Crown Point Community School Corporation
Diet Modification Form

Office Use Only:
Received: _____
POS: _____
PCS SD: _____

PART A: COMPLETED BY THE PARENT/GUARDIAN

Student ID#	Student's Last Name	Student's First Name	Date of Birth

Request Type: ☐ Initial Order ☐ Revision ☐ Cancel Previous Diet Order

Which meals provided by the cafeteria will your student eat? ☐ Breakfast ☐ Lunch

☐ My child has a special diet and will NOT eat food from the cafeteria

Does the student have an IEP or 504 Plan? If yes, describe any meal accommodations required: Yes ☐ No ☐ Describe: _____

Parent/Guardian Information: Name | **Phone Number** | **Mailing Street Address (only include city & zip if living outside Crown Point)**

E-mail Address (We will use this to send acknowledgement and details of your student's menu plan. PLEASE PRINT NEATLY

Lactose Intolerance does not require medical signature (different than milk allergy)

☐ Student is Lactose Intolerant

Substitute cow's milk with: ☐ Lactose Free Milk (Lactaid) ☐ Soy Milk

NEXT

Mark if the student CANNOT eat: ☐ Cheese ☐ Yogurt ☐ Ice Cream

I consent that this information is correct, and to the exchange of information between the Healthcare Provider and district/school personnel, as needed.

Parent / Guardian Signature (required for processing) _____ **Date** _____

PART B: COMPLETED BY THE PHYSICIAN / MEDICAL AUTHORITY ONLY (do not need to fill out this section if student is only lactose intolerant)

STUDENT DIAGNOSIS OR CONDITION

☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy - Check appropriate box: ☐ Ingestion ☐ Contact ☐ Inhalation

Select major life activities affected: ☐ Eating ☐ Digestion ☐ Learning ☐ Other: _____

Please select all foods to **OMIT** from student's diet during the school day due to the above noted disability:

Peanuts and Tree Nuts (Mark all that apply)
☐ Peanuts
☐ Tree Nuts specify: _____

Fish or Shellfish (Select all that apply)
☐ Fish ☐ Shellfish

Wheat / Gluten
☐ All menu items with wheat/gluten listed as an ingredient

Sesame (Select all that apply)
☐ Sesame Oil ☐ Sesame Seed

Dairy (ALL DAIRY PRODUCTS)
[Note: This is for true milk/milk protein **ALLERGY**, not intolerance, if your student is lactose intolerance fill out the section with bold outline just above parent signature
☐ All food/beverages with milk listed as an ingredient including baked goods
Substitute Fluid Milk with: ☐ soy milk ☐ water

Egg (Select ONLY ONE)
☐ Whole eggs such as scrambled eggs or hard cooked eggs
OR
☐ All menu items with egg listed as an ingredient

Soy
☐ Soy Lecithin
☐ Soy Protein (concentrate, hydrolyzed, isolate)
☐ Recipes with any type of soy listed as an ingredient

Other:
☐ Other, please specify below (include if allergen is only for fresh, cooked, or both):

_____
_____
_____

FOOD TEXTURE MODIFICATION
If needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

THICKENED LIQUIDS:
If needed check ONE: ☐ Honey ☐ Nectar

LICENSED MEDICAL AUTHORITY INFORMATION ***Diet Order Form will be returned to parent / guardian and NO accommodations will be made if this section is not complete.***

Medical Office Stamp (required for processing)

Phone Number (if not on stamp) _____

Medical Authority Signature X _____ Date _____

Fax Number _____

Medical Authority Printed Name _____

This institution is an equal opportunity provider.

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DO NOT WRITE IN THIS AREA