

Olentangy Local Schools

Food Allergy/Disability/Special Dietary Needs Form for 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 schools 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: _____ Cell phone: _____
Address: _____ Home phone: _____

**Part B: Life Threatening Food Allergy Medical Professional Statement: To Be Completed by a Medical Professional
(If there is no life threatening food allergy, skip this section and go to Part C)**

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 foods that must be omitted:

Milk Peanut Tree Nut Egg Fish Shellfish Wheat Soy Sesame

Other life threatening food allergy, please specify _____

2. Can the student consume foods where the allergen is an ingredient in the food product? ____ YES ____ NO
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)

Additional detail _____

3. Explanation of why this disability restricts diet: _____

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

____ eating ____ caring for oneself ____ performing manual tasks ____ walking
____ hearing ____ speaking ____ breathing ____ learning
____ seeing ____ operation of major bodily function (immune system, bowel, digestive, brain, etc.)
____ Other, specify _____

5. Foods to substitute:

Medical Professional's Signature: _____ Date: _____

Clinic/Facility Name & Address: _____ Telephone: _____

**Part C: Disability Medical Professional Statement: To be Completed by a Medical Professional
(If there is no disability, skip this section and go to Part D)**

I declare the student listed above to possess a Disability. _____
Medical Professional's name (printed)

1. Circle all disabilities requiring meal modification:

Autism	Cancer/leukemia	Drug addiction/alcoholism
Cerebral palsy	Traumatic brain injury	Metabolic disease,
Epilepsy	Orthopedic impairment	specify _____
Speech impairment	Intellectual Disability	Hemophilia
Visual impairment	Heart disease	Rheumatic fever
Hearing impairment	HIV	Nephritis
Muscular dystrophy	Tuberculosis	Specific learning
Multiple sclerosis	Emotional Disturbance	disabilities

Part C Continued:

2. Explanation of why this disability restricts diet: _____
3. Major life activity affected by the life threatening food allergy (check all that apply) :
____ eating ____ caring for oneself ____ performing manual tasks ____ walking
____ hearing ____ speaking ____ breathing ____ learning
____ seeing ____ operation of major bodily function (immune system, bowel, digestive, brain, etc.)
____ Other, specify _____
4. Foods to omit:

5. Foods to substitute:

Medical Professional's Signature: _____ Date: _____
Clinic/Facility Name & Address: _____ Telephone: _____

Part D: Other Medical or Special Dietary Needs Medical Professional Statement: To be Completed by a Medical Professional

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:

Medical Professional's Signature: _____ Date: _____
Clinic/Facility Name & Address: _____ Telephone: _____

Non-Discrimination Statement

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Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** program.intake@usda.gov.

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