



MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

Please return completed and signed form to your school's Health Office/Nurse.

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 soy bean 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:

