



DIETARY MODIFICATION FORM

PARENT/GUARDIAN: RETURN FORM TO SCHOOL NURSE

Parent/Guardian Name _____ Student Name _____
Campus Name _____ Student Grade _____

Physician's Diet Modifications

Please complete this page for DISABILITIES REQUIRING PHYSICIAN'S DIET MODIFICATION. The U.S. Department of Agriculture School Meals Program requires that all questions be answered in order for dietary substitutions and/or modifications to be made.

PHYSICIAN'S STATEMENT

I _____, physician for _____
(Physician's Name (please PRINT) Child's Name (please PRINT))

declare the herein mentioned child to possess the following severe/life threatening food allergies and/or special dietary needs related to a disability.

Disability requiring meal modification: _____

If food allergy, is it LIFE THREATENING? _____ yes _____ no

Explanation of why disability restricts diet _____

Major life activity affected by the disability _____

Foods to Omit _____

Foods to Substitute _____

Physician's Signature

Phone