

MODIFIED MEAL REQUEST FORM

For Use in the USDA School Nutrition Programs, Child, and Adult Care Food Program, & Summer Food Service Program

*This form may be used to request meal modification for a child with a physical or mental impairment that restricts their diet. **Portions of this form must be completed by a State Licensed Healthcare Professional who is authorized to write medical prescriptions under Illinois law.***

SECTION 1: CHILD INFORMATION

Child's Name: _____ Date of Birth: _____
School Name: _____ Grade: _____

SECTION 2: MEAL MODIFICATION INFORMATION

TO BE COMPLETED BY A STATE LICENSED HEALTHCARE PROFESSIONAL

CHECK ONE:

- ☐ Participant has a disability or a medical condition that requires special meals or accommodations. (e.g., juvenile diabetes, allergy to peanuts, etc.) **A licensed physician must sign this form.**
- ☐ Participant does not have a disability but is requests special meals or accommodations due to food intolerance(s) or other medical reasons. **A licensed physician must sign this form.**
- ☐ Participant does not have a disability or food intolerance, but requests special meals and/or accommodation due to household preference, i.e. religion, vegetarian, vegan, etc. **A Parent/Guardian must provide his/her signature, printed name and date below. *District will determine if the meal accommodation request will be granted contingent on a case-by-case basis**

DISABILITY OR MEDICAL CONDITION REQUIRING SPECIAL MEALS OR ACCOMMODATIONS:

IF PARTICIPANT HAS DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY:

DIET PRESCRIPTION AND/OR ACCOMMODATION: (PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)

Section 3: FOODS TO BE OMITTED AND SUBSTITUTIONS:

(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)

A. Foods To Be Omitted

B. Suggested Substitutions

_____	_____
_____	_____
_____	_____
_____	_____

SECTION 4: SIGNATURES

Parent/Guardian Name Printed: _____	Relationship: _____
Phone: _____	Email: _____
Parent Guardian Signature: _____	Date: _____
Medical Authority Name First and Last Printed: _____	
Medical Authority Signature: _____	Date: _____

MODIFIED MEAL REQUEST FORM – CONTINUED

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SECTION 5: SEND COMPLETED FORMS TO

Name: Shira Patterson

Email: spatterson@ecusd7.org

Mailing Address: 708 St. Louis Street

Title: Coordinator of Food Service

Edwardsville, IL 62025

Facility: District 7 Central Office

SECTION 6: SPONSOR/SCHOOL FOOD AUTHORITY USE ONLY

Date Received: _____ Received By: _____

Date(s) of Follow-Up Communication*: _____

* Attach documentation of pertinent information received from any follow-up communication to this form.

Nondiscrimination Statement

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Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, 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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