

Student Name: _____ Date of Birth ____/____/____



Parent Request for School Meal Accommodation and Physician's Prescription for Food Allergy

Student Name: _____ Student ID Number: _____ Date: ____/____/____

USDA regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities (including life threatening allergic reactions) restrict their diets. A child with a disability will be provided substitutions in foods when supported by a statement signed by a licensed physician. The statement must identify: the child's disability, an explanation of why the disability restricts the child's diet, the major life activity affected by the disability, and the food(s) that must be omitted and/or substituted from the child's diet. Accommodations will be initiated upon receipt of physician directions on this modified school lunch form.

Signing below consents to communication between school health professionals and the physician regarding the student listed above.

Signature of Parent/Guardian _____ Phone Number(s) _____

MEDICAL DIAGNOSIS: _____

LENGTH OF DIETARY RESTRICTION:

- Temporary until _____ Life Long

WEIGHT REDUCTION DIET

- Calorie Restriction: _____ calories/meal
 Substitute Fruit for any Dessert
 Skim Milk Only

WEIGHT INCREASE DIET

- Calorie Goal: _____ calories/meal
 High Protein: _____ g Protein/meal
 High CHO Diet: _____ g CHO/meal

DIABETIC DIET

- _____ grams CHO at Breakfast _____ grams CHO at Snack
 _____ grams CHO at Lunch No restriction

RENAL DIET

- _____ gram Sodium restriction _____ gram Phosphorus restriction
 _____ gram Potassium restriction _____ gram Protein allowed

CARDIAC DIET

- _____ gram Sodium restriction Other: _____
 _____ gram Fat restriction

TEXTURE MODIFICATION

- Chopped or Bite sized foods
 Pureed
 Thickened Liquid to _____ Consistency.
(use _____ teaspoon(s) of thickener per oz liquid)

OTHER NEEDS

- Fiber Additives (provided by parent)
 MCT Oil or Other Caloric Enhancer (provided by parent)
 Meal replacements (prescription including formula, dosage and time must be provided)

Food Allergy Note:

When a food allergy results in a severe, life-threatening (anaphylactic) reaction, the child's condition would meet the definition of "disability" and omissions or substitutions prescribed by the physician will be made for the student with food allergy. Please list any substitutions. *Food intolerance is not defined under Section 504 of the Rehabilitation Act as a disability.*

TYPE OF ALLERGIC REACTION

- Rash/Hives
- Stomach Discomfort
- Anaphylaxis
- Diarrhea
- Swelling

Below are the most common allergies. Please check the appropriate boxes. Use the "OTHER" section to include any food allergies not listed. Do not rely on a list of prepackaged foods. Ingredients can change often and without notice.

EGGS <i>(please check one)</i>	<input type="checkbox"/> Allowed in Cooking	<input type="checkbox"/> Not Allowed in Cooking
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MILK:	Please check one:	<input type="checkbox"/> Lactose Intolerance (student will be given the option of lactose free milk)	<input type="checkbox"/> Milk Allergy (student will be given the option of 100% juice or water)
	Please check one:	<input type="checkbox"/> Avoid fluid milk only	<input type="checkbox"/> Milk allowed in cooking (excludes dairy products such as cheese, yogurt, etc.) <input type="checkbox"/> Milk not allowed in cooking

CORN <i>(check all that apply)</i>	<input type="checkbox"/> Avoid whole kernels only <input type="checkbox"/> Avoid corn derivatives (includes food starch, modified food starch, cornmeal, grits, corn flours, corn starch, corn syrup, corn syrup solids, vegetable starch, vegetable gum, baking powder)	<input type="checkbox"/> Avoid corn protein
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FISH/SHELLFISH <i>(check all that apply)</i>	<input type="checkbox"/> Avoid fish	<input type="checkbox"/> Avoid shellfish	<input type="checkbox"/> Avoid area when cooking
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PEANUTS <i>(check all that apply)</i>	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Touch <i>(student will be offered alternative seating within the cafeteria)</i>	<input type="checkbox"/> Inhalation* <i>(student will be offered an alternative location outside of the cafeteria)</i>
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*Inhalation protocols include removing the child from the lunch room. This precaution is due to the fact that we cannot guarantee what another student brings from home. Please use with appropriate discretion.

TREE NUTS <i>(check all that apply)</i>	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Touch <i>(student will be offered alternative seating within the cafeteria)</i>	<input type="checkbox"/> Inhalation* <i>(student will be offered an alternative location outside of the cafeteria)</i>
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*Inhalation protocols include removing the child from the lunch room. This precaution is due to the fact that we cannot guarantee what another student brings from home. Please use with appropriate discretion.

WHEAT:	<input type="checkbox"/> Avoid globulins	<input type="checkbox"/> Avoid albumins	<input type="checkbox"/> Avoid gliadins	<input type="checkbox"/> Avoid glutenins
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GLUTEN:	<input type="checkbox"/> Avoid wheat	<input type="checkbox"/> Avoid barley	<input type="checkbox"/> Avoid rye	<input type="checkbox"/> Avoid oats
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SOY:	<input type="checkbox"/> Avoid soy protein	<input type="checkbox"/> Avoid soy byproducts	<input type="checkbox"/> Avoid soybean oil <i>(Soybean oil may not be listed as an allergen as it is highly refined and often unlikely to cause a reaction)</i>
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OTHER:	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Physician's Name: _____ Physician's Signature: _____

Address: _____ Phone Number: _____

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