

Diet Modifications for Meals at School for Children with a Diagnosed Life-Threatening Food Allergy or Disability

Name of Student: _____

Diagnosis of disability or life-threatening food allergy that requires the student to have a diet modification.

Include a brief description of the major life activity affected by the student's condition:

FOODS TO BE OMITTED and SUGGESTED SUBSTITUTIONS:

Please check the food group(s) to be omitted. List specific foods to be omitted and suggest substitutions. Use the back of this form or attach additional information as needed.

FOODS TO OMIT

SUGGESTED SUBSTITUTIONS

Milk/Dairy Products

Eggs/Egg Products

Soy/Soy Products

Peanuts/ Tree Nuts

Fish/ Shellfish

Other

TEXTURE ALLOWED:

Regular

Chopped

Ground

Pureed

Other detailed information regarding diet or feeding:

I certify that the above named student needs diet modifications as described above because of the student's disability or life-threatening food allergy:

Licensed Physician's Signature

Office Phone

Date

Physician's Printed Name

I understand that if my child's medical needs change, it is my responsibility to notify the school and to provide an updated Diet Modification Form completed by the physician. I give my permission to share the information on this form with the individuals who take part in the care of my child during the school day.

Parent/Guardian's Signature

Home Phone

Date

- School Nurse
- Cafeteria Manager