



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 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): \_\_\_\_\_ Email: \_\_\_\_\_

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 Lunch
- \_\_\_\_\_ grams CHO at Snack
- No restriction

#### RENAL DIET

- \_\_\_\_\_ gram Sodium restriction
- \_\_\_\_\_ gram Potassium restriction
- \_\_\_\_\_ gram Phosphorus restriction
- \_\_\_\_\_ gram Protein allowed

#### CARDIAC DIET

- \_\_\_\_\_ gram Sodium restriction
- \_\_\_\_\_ gram Fat restriction
- Other: \_\_\_\_\_

#### 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)



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(2) fax: (202) 690-7442; or

(3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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