Diet Modification Form

This form must be completed and signed by a physician. Return to the Main Office at your child's school. **A new form is required every school year.**

School Year: ______________________________ **School:** ______________________________

Student's Name: ______________________________ **Date of Birth:** __________ **Grade:** ________

Food Allergies & Intolerances

Please indicate if an allergy is ***life threatening***. Unless otherwise noted, all foods marked will be eliminated from the student's school meal and a substitute provided.

	Life Threatening?		Life Threatening?
☐ Peanut	Yes/No	☐ Shellfish (not served in school meals)	Yes/No
☐ Dairy	Yes/No	☐ Gluten intolerance	Yes/No
☐ Wheat	Yes/No	☐ Lactose intolerance	Yes/No
☐ Oats	Yes/No	☐ Other:	Yes/No
☐ Soy	Yes/No	☐ Other:	Yes/No
☐ Corn	Yes/No	☐ Other:	Yes/No
☐ Egg	Yes/No	☐ Other:	Yes/No
☐ Fish (specify)	Yes/No	☐ Other:	Yes/No

Comments & specific instructions:

Food Texture Modifications

Describe any texture modification prescribed. Specify which types of foods should be modified and/or omitted.

Signature Required

______________________________ ______________________________ __________

Physician Name (printed) & Signature | Phone # | Date