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 _____	_____
( ) Wheat/Wheat 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**

Adapted from the Handbook for Children with Special Food & Nutrition Needs – NFSMI Item #ET69-06
In accordance with the Maryland State Department of Education Management and Operations Memorandum #16 (4/00)
CC: ☐School Nurse ☐School Cafeteria Manager ☐Student's School File ☐Food Services Office