MSD15
FOOD & NUTRITION SERVICES

Food & Nutrition Services Department

ANNUAL MODIFIED MEAL REQUEST FORM

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (Last, First): _____

School: _____ Grade: _____ Parent/Guardian Phone: _____

Parent/Guardian Name: _____ Email: _____

My child will require a menu modification at the following: ☐ Breakfast ☐ Lunch

I understand it is my responsibility to renew this form before each school year and any time my child's medical or health needs change.

Parent/Guardian Name PRINTED	Parent/Guardian SIGNATURE	Date

TO BE COMPLETED BY MEDICAL AUTHORITY

The Dietary Needs below are related to (ex: Celiac Disease, Lactose Intolerance)

Food To BE OMITTED from diet* (check appropriate boxes below)

- ☐ **Milk** – Fluid milk, cheese, yogurt, and other dairy ingredients such as casein and whey.
- ☐ **Fluid Milk** – Milk to drink
- ☐ **Peanuts** – Peanuts, Peanut Butter, Peanut oil.
- ☐ **Tree Nuts** – Almonds, hazelnuts, and cashews.
- ☐ **Wheat** – Wheat-based grains such as buns, crackers, pasta, and wheat as an ingredient.
- ☐ **Gluten** – Wheat, rye, barley, and non-certified oats.
- ☐ **Fish** – Fin-fish such as cod and tilapia
- ☐ **Shellfish** – Shrimp and crab
- ☐ **Egg** – Visible egg in a dish such as an omelet
- ☐ **Egg Ingredients** – Visible egg in a dish and egg as an ingredient
- ☐ **Soybean** – Food items such as Textured Soy Protein (TSP), Textured Vegetable Protein (TVP), tofu, and whole soybeans (edamame).
- ☐ **Soybean Ingredients** – TSP, TVP, soy protein concentrate, soy protein isolate, soy sauce, soy flour, unrefined soy bean oil, and tofu.
- ☐ **Other** - _____

**Examples of individual food allergens provided are not all-inclusive, other foods may apply.*

Food Allergen Management Plan

What are the student's possible reactions to the indicated allergen(s) or conditions?

_____

_____

REQUIRED List all acceptable safe food substitutes **(the modified request cannot be accommodated until this portion is completed):**

_____

_____

Additional Comments: _____

_____

Prescribing Physician/Medical Authority Name Printed	**Prescribing Physician/Medical Authority Signature**

FNS NOTES

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