



Diet Modification Form

This form must be completed and signed by a physician. Return to the Foodservice Manager 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?

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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