Harvey School District 152

MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

Please return completed and signed form to the Nurse's office at either school

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (Last, First): _____ Grade: _____

School: _____

Parent/Guardian Email: _____ Daytime Phone: _____

Based on information listed below my child will require a menu modification at the following: ☐ Breakfast ☐ Lunch ☐ Afterschool Snack ☐ Supper ☐ Other _____

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

Parent/Guardian Name PRINTED | Parent/Guardian SIGNATURE | Date

TO BE COMPLETED BY MEDICAL AUTHORITY (Licensed by State of Illinois to prescribe medication)

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

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

- ☐ **Dairy** – 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** – Finfish such as cod and tilapia
- ☐ **Shellfish** – Shrimp and crab
- ☐ **Egg** – Visible egg in a dish such as an omelet
- ☐ **Egg Ingredients** – Egg white, egg yolk or whole egg as an ingredient
- ☐ **Soybean** – Textured Soy Protein, Textured Vegetable Protein, tofu, and whole soybeans (edamame).
- ☐ **Soybean Ingredients** – Soy protein concentrate, soy protein isolate, soy sauce, soy flour, and unrefined soybean oil
- ☐ **Other** - _____

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

Adjustment to meal preparation (i.e., food puree) and /or serving time(s):

Food Management Plan

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

REQUIRED List all acceptable and safe food or beverage substitutes:

Comments: _____

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

FOR FOOD SERVICE NOTES (Other information, please see back)

Date Received:	By: (employee signature)
Date Implemented:	By: (employee signature)
Other information:	