Return To:
Owego Apalachin CSD
Food Service Department
1 Sheldon Guile Blvd., Owego, NY 13827
Attn: Sandy Phillips

MEAL MODIFICATIONS AT SCHOOL

Name of Student: _____ **School:** _____ **Grade:** ____

Description of Physical or Medical Impairment:

_____

_____

Food Allergies

□ Egg □ Fish □ Peanut □ Shellfish □Tree Nut □ Soy □Wheat
□ Milk □ Lactose Intolerance □ Other: _____

Is this condition permanent or temporary? □ Permanent □ Temporary
If temporary, please give length of time instructions are to be followed with explanation:

_____

_____

Diet Prescription: (Check all that apply)
__ Allergies (Describe) _____
__ Other (Describe) _____

Foods Omitted: _____

Substitutions: □Specified Substitutions: _____

□Substitutions as per BOCES Registered Dietitian

Other Information Regarding Meal Modifications: (Please provide additional information below or attach to this form.)

I certify that the above-named student needs meal modifications as described because of the student's physical or medical impairment.

Medical Professional's Signature Office Phone Number Date

Medical Professional's Signature

Address

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