NORTHWEST SUBURBAN EDUCATION ASSOCIATION

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

MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

Please return completed and signed form to <INSERT STAFF NAME, EMAIL, DROP OFF LOCATION>

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** – Fin-fish 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 soy bean 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:	