School City of Hammond
Department of Food & Nutrition
DIET MODIFICATION REQUEST FORM

Form is to be completed by an authorized medical professional (milk/lactose intolerance does not require medical approval)
Return completed form via fax, email scan, or mail.
Fax: 219-554-4502 I Email: crclarahan@hammond.k12.in.us
Address: Dept of Food & Nutrition 41 Williams St Hammond, IN 46320

Nutrition and allergen information is available via **MealViewer** to help you plan your child's meals in a way that fits with your dietary and religious preferences. MealViewer can be accessed here: www.schlunch.com **OR** users can download the **MealViewer To Go App** available for Apple and Android devices.

Section I : STUDENT INFORMATION - To be completed by Parent/Guardian

Student ID Number | Last | First | MI | Date of Birth

PARENT / GUARDIAN INFORMATION

First, Last | Daytime Phone Number

Mailing Address, City, State, Zip

Section II : I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Department of Food & Nutrition and the school nurse. I consent to the exchange of information between the physician and school as needed.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

E-mail Address (We will use this to send acknowledgement and details of your child´s menú plan. PRINT NEATLY)

Section III : Does the student have a disability, medical condition, or severe food allergy warranting a special diet? ☐ **Yes** ☐ **No**

A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

If **"YES"**, please check all that ☐ **Food Allergy** ☐ **Food Intolerance** ☐ **Other (explain):** _____

If **"NO"**, a special diet is not warranted.

Please Note: The Department of Food & Nutrition will attempt to accommodate non-life threatening food allergies or intolerances, but reserves the right to modify the menu based on product availability.

If the student's disability or medical condition requires texture modification please specify: _____

Section IV : Student Diagnosis or Condition (Select 1) ☐ **Food Intolerance** ☐ **Food Allergy** ☐ **Life Threatening Food Allergy**

Please select all foods to omit from student's diet during the school day (not to be used as a medical history):

Dairy (Select all that apply)
- ☐ Fluid Milk (substitute with Lactaid)
  For students who are lactose intolerant
- ☐ Fluid Milk (substitute with soy milk)
  For students with a true milk allergy
- ☐ Yogurt
- ☐ Ice Cream
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ All menu items with any dairy listed as an ingredient

Egg
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ All menu items with any egg listed as an ingredient

Wheat / Gluten
- ☐ Menu items with any wheat listed as an ingredient

Fish or Shellfish (Select all that apply)
- ☐ Fish
- ☐ Shellfish

Nuts (Select all that apply)
- ☐ Peanuts
- ☐ Tree Nuts specify: _____

Soy (Select all that apply)
- ☐ Soy Lecithin
- ☐ Soy Protein (concentrate, hydrolyzed, isolate)
- ☐ Menu items with any soy listed as an ingredient

Other:
- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

_____

_____

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/Life Threatening food allergy or food intolerance/allergy as indicated.

Name of Medical Authority _____ ☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP** ☐ **SLP**
(PLEASE PRINT)

Prescribing Physician/Medical Authority _____ _____
(SIGNATURE) (DATE)

Contact Number _____

This institution is an equal opportunity provider. 1090342830

DO NOT WRITE IN THIS AREA