AHSD25 Annual Modified Meal Request Form

Name of Student (First & Last): School: Parent/Guardian Contact Name: Contact(s) Phone: Contact(s) Phone: Contact(s) Email: My child will require a menu modification at the following meal services: Lunch Breakfast (only available at select schools) Lunderstand it is my responsibility to renew this form before each school year and any time my child's medical or health needs

Parent/Guardian Name PRINTED Parent/Guardian SIGNATURE

change.

Date

TO BE COMPLETED BY MEDICAL AUTHORITY

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

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

Fluid Milk – Milk to drink

Milk - Fluid milk, cheese, yogurt, and other dairy ingredients such

as casein and whey.

Peanuts - Peanuts, Peanut Butter, Peanut oil.

Tree Nuts - Please specify:

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 – Visible egg in a dish and egg as an ingredient

Soybean – Food items such as Textured Soy Protein (TSP), Textured

Vegetable Protein (TVP), tofu, and whole soybeans (edamame).

Soybean Ingredients – TSP, TVP, soy protein concentrate, soy

protein isolate, soy sauce, soy flour, unrefined soy bean oil, and tofu.

Sesame – sesame as an ingredient.

Other -

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

Food Allergen Management Plan

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

REQUIRED List all acceptable safe food substitutes:

Student meal prep should follow Severe Food Allergy SOP to avoid cross contamination during cook, prep and packing

Student meal can be prepared and/or cooked with other student meals and does not need to follow Severe Allergy SOP.

Prescribing Physician/Medical Authority Name Printed

Prescribing Physician/Medical Authority Signature

FNS Dept Notes: