

2011-2012 form must be faxed from the medical professional's office to
School Food and Nutrition Services of New Orleans, Inc. FAX: 504-596-3459 Phone: 504-596-3452
For the safety of this student, this form MUST be thoroughly and legibly completed.

SCHOOL MEAL MODIFICATION FORM

Section A: Completion by parent or guardian required.

Student Information: Name: _____ Age: _____

School: _____ School City: _____ Grade/Classroom: _____

Parent/Guardian Contact: Name: _____ Phone: _____

Address: _____ Email (optional): _____

Section B: Completion by MEDICAL AUTHORITY required.

1. Is this student's medical condition a disability? ___ Yes OR ___ No

Medical Condition: _____

2. Remove the following from student's meals (mark all that apply as Intolerance **OR** Allergy):

Food Intolerance:

- ___ Eggs- pure form only
- ___ Milk- beverage form only*
* Substitute (please circle): Juice or Water
- ___ Milk AND Dairy only*
* Substitute (please circle): Juice or Water
- ___ Soy- pure form only
- ___ Wheat- whole or unprocessed only
- ___ Other _____

Allergy: Eliminate **ALL** foods that may

contain any form of:

- ___ Eggs Proteins
- ___ Fish
- ___ Milk Proteins
- ___ Nuts
- ___ Peanuts
- ___ Shellfish
- ___ Soy
- ___ Wheat
- ___ Other _____

Any Other Specific Dietary Need: _____

3. Specific Foods to Omit

Specific Foods to Substitute*

*Please note if juice or water may be substituted for liquid milk. If juice or water substitution is not noted on diet prescription form, student will be charged for juice or water.

I certify that the above named student has special dietary needs as described above due to the student's medical condition.

Office Address: _____ Office Telephone: _____
_____ Office Fax: _____

Licensed Physician/Recognized Medical Authority Signature

Date