When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school.



Return this form to your child's school. This form, **along with the Individualized Healthcare Plan**, must be filled out completely and submitted before any meal substitutions can be made for children who have allergies or other disabilities. Any midyear changes require the submission of a new form signed by the child's physician.

Part 1 to be comp	leted by pa	arent/guardia	an. Please	print					
					П				
Student ID	Stude	nt's First Name	• •		Student's	Last Name			
Student's date of birth		School		1					
Parent/guardian's name	9			 Email	Address				
(П. Г)		7- [TTT) [7
Work Phone			Cell Phone				Home Phon		J
Please note: CCPS Food & Nutrition Department may need to contact the referring LHP for clarification of information provided on this form, if needed									
Part 2 to be comp	leted by lie	ensed physic				or nurse r	oractition	er). Please	print.
		ife Threatenir				(Section		,	
	=		_	٠.	J\/	(Section	•		
Check those that apply	=	Non-Life Threatening Food Allergy (Section B) actose Intolerant (Section C)							
τηστ αρριγ	Modification of Food Texture (Section C) [Section C] [Section C] [Section C]								
Danawinskian of Childle	iv	Tourneation	ii roou iex	ture		(Section	ID) FIE	ase see Do	————
Description of Child's Physical or Mental									
Impariment Affected									
Section A- Life Threatening Allergies (please check all that apply)									
_	anuts	_	Tree nuts			Fish		○ Shel	lfish
	○ Milk	This allergen c	an be consur	ned as an	ingredient	(i.e. baked	in) O Yes	O No	
	○ Eggs	This allergen c	an be consur	ned as an	ingredient	(i.e. baked	in) O Yes	O No	
	○ Soy	This allergen c	an be consur	ned as an	ingredient	(i.e. baked	in) O Yes	O No	
	○ Wheat	This allergen c	an be consur	ned as an	ingredient	(i.e. baked	in) O Yes	O No	
Other- please specify									
If substitution is necessary for above allergy, please list the approved substitution for the foods omitted (i.e. if the student has a									
life-threatening allergy to milk, indicate whether the student should receive juice or water in place of milk):									
Section B- NON Life	Threateni	ng Allergies							
This student ha	s a NON-life	e-threatening f	ood allergy	that res	tricts the	diet (pleas	se specify f	ood)	
List foods to be omitted from diet and list any approved substitutions for those foods:									
Section C-Lactose In	ntolerant								
This Student is Lac		ant. O _{Yes}	O _{No}	May the	e student	have lacto	se free mil	k? O ye	es O _{No}
		ne only substituti		•					
LHP's name							e phone	()	
							Number	()	
LHP's signature						Date			

fice Use Only									
ection C-Food Mo	ndification								
	List modifications of food texture or consistency that are necessary (describe the patient's disability, major life								
	the disability and approved substitution/modification if any)								
Description of C	Child's Physical or Mental Impariment Affected:								
-,-	-,								
: 									
	ode To Do Omittod								
Foods To Be Omitted Suggestd Substitutions									
Modification	rase check the appropriate texture modification								
	Pureed Naching Council								
	Machine Ground								
If This leave and	Other(specify)								
If Thickened:	Pudding Consistency (liquids are spoonable)								
	Honey Consistency (liquids can be poured but very slowly)								
	Nectar Consistency (tomato juice consistency)								
	Other (please specify)								
Explanation of I	Diet Prescription to ensure proper implementation:								

Please make sure LHP Signs the form on the front

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