SCHOOL MEAL MODIFICATION FORM

****WE DO NOT HAVE ALLERGY FREE KITCHENS. CROSS-CONTAMINATION IS A RISK!****

LIST IS NOT INCLUSIVE. SUBSTITUTIONS MAY BE MADE AT ANYTIME.

Please send COMPLETED Form to Archdiocese of New Orleans SFNS.

Fax: 504-596-3459 Mail: 1000 Howard Ave. Ste. 300, New Orleans 70113 Inquiries: 504-596-3434

All incomplete forms will be returned to the Parent.

Section A: Completion required to prevent delayed processing.

Student Name: _____ Grade: _____ School:_____

Date of Birth:_____

Parent/Guardian Name: _____Phone / Email:_____

Section B: Completion by MEDICAL AUTHORITY required.

IS THIS STUDENT'S MEDICAL CONDITION A DISABILITY? ____Yes OR ____No

Food Allergies, Intolerances, and Dietary Needs (please mark ALL that apply):

MILK: ____ Beverage* **OR** ____ ALL Dairy* **OR**____ ALL foods*-"May Contain Milk"

*** SUBSTITUTE FOR BEVERAGE MILK (please circle): Juice or Water**

PEANUTS/NUTS: ____ ALL foods- "May Contain/Manufactured Nuts/Peanuts"

SHELLFISH: ____ ALL foods- "May Contain Shellfish"

FISH: ____ ALL foods- "May Contain Fish"

WHEAT: ____ Whole wheat only **OR** ____ ALL foods- "May Contain Wheat"

EGGS: ____ Pure form only (egg white/egg yolk) **OR** ____ ALL foods - "May Contain Egg"

SOY: ____ Pure form only **OR** ____ ALL foods- "May Contain Soy"

CORN: ____ Pure form only (Whole Kernel) **OR** ____ ALL foods- "May Contain Corn"

OTHER ALLERGEN: _____

OTHER SPECIFIC DIETARY NEED: _____

OTHER SPECIFIC OMISSION: _____

SPECIFIC SUBSTITUTION NEEDED: _____

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

Medical Authority Name (print): _____

Medical Authority Telephone Number: _____

Medical Authority Signature and Date: _____