School Meal Modification Form

Section A (*To be completed by Parent/Guardian):*
Student Name: _____ Grade: _____ School: _____

Date of Birth: _____ Student ID: _____

Parent/Guardian Name: _____ Phone/Email: _____

Religious Modifications (if applicable): _____

Section B (*To be completed by Medical Provider):*
Is this Student's medical condition a disability? ☐ Yes ☐No

Diet Prescription (if applicable):
☐Diabetic (Carbohydrate Counting)
☐Celiac Disease
☐Other (Please Specify): _____

Food Intolerances (Digestive system response, i.e. nausea, bloating, diarrhea, headaches, etc.)

☐ Lactose Intolerance (eliminate fluid milk – lactose free milk or juice/water available)
☐ Yes ☐No Allow foods containing dairy (such as cheese, yogurt, sour cream, milk in baked goods)

☐ Egg Intolerance (eliminate whole eggs, yolk, egg white)
- ☐ Yes ☐No Allow Eggs as ingredients in foods (such as baked desserts, pasta, mayo)

☐ Wheat Intolerance (eliminate breads, pizza, baked goods, pasta, other grain products)
- ☐ Yes ☐No Allow foods containing small amount of wheat (such as breading on chicken products, roux in gumbo, sauces)

☐ Other Intolerance (please specify) _____

Food Allergies (Immune System Response):

☐ Eggs (All foods that may contain egg)
☐ Tree Nuts (All foods that may contain tree nuts)
☐ Milk (All foods that may contain milk)
☐ Fish (All foods that may contain fish)
☐ Wheat (All foods that may contain wheat)
☐ Soy (All foods that may contain soy)
☐ Shellfish (All foods that may contain shellfish)
☐ Sesame (All foods that may contain sesame)
☐ Peanuts (All foods that may contain and manufactured peanuts)
☐ Other (please specify) _____

Section C (Change in Diet Prescription):
Special Diet Status has **CHANGED** as indicated: ☐ Student no longer needs special diet ☐ Update the special diet as reflected on this form

Section D (*To be completed by Medical Provider - **REQUIRED):***
I certify that the above-named student needs modified school meals prepared as described above because of the student's disability, medical condition and/or allergy/intolerance.

Medical Authority Name (print): _____ Phone Number: _____

Medical Authority Signature: _____ Date: _____

Please Note: We do not have allergy free kitchens for food prep. Cross-contamination is a risk.
This document is in effect for the current school year and must be renewed ONLY if there are changes to the student's diet. All incomplete forms will be returned to the parent/guardian.
Please send completed forms to School Food and Nutrition Services of New Orleans, Inc. or to your school's Cafeteria Manager.

ARCHDIOCESE OF NEW ORLEANS
School Food and Nutrition Services of New Orleans, Inc.

School Food and Nutrition Services
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