Hancock County Schools Nutrition Services

MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

Please return completed and signed form to Pam Ramsey, AFSD, at pam.ramsey@hancock.kyschools.us or Fax: 270-927-6916

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (Last, First, Middle Initial): _____Grade:_____

School: _____

Parent/Guardian Email: _____ Daytime Phone: _____

Based on information listed below, my child will require a menu modification at the following: ☐ Breakfast ☐ Lunch ☐ Afterschool Supper

I understand it is my responsibility to renew this form any time my child's medical or health needs change.

_____ _____ _____

Parent/Guardian Name PRINTED | Parent/Guardian SIGNATURE | Date

TO BE COMPLETED BY MEDICAL AUTHORITY (Licensed by State of Kentucky or Indiana to prescribe medication)

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

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

☐ **Fluid Milk** – Milk to drink
☐ **Dairy** – Fluid milk, cheese, yogurt, and other dairy ingredients such as casein and whey
☐ **Peanuts** – Peanuts, Peanut Butter, Peanut oil
☐ **Tree Nuts** – Almonds, hazelnuts, and cashews.
☐ **Fish** – Fin-fish such as cod and tilapia
☐ **Shellfish** – Shrimp and crab
☐ **Egg** – Visible egg in a dish such as an omelet
☐ **Egg Ingredients** – Egg white, egg yolk or whole egg as an ingredient
☐ **Soybean** – Textured Soy Protein, Textured Vegetable Protein, tofu, and whole soybeans (edamame)
☐ **Soybean Ingredients** – Soy protein concentrate, soy protein isolate, soy sauce, soy flour, and unrefined soy bean oil
☐ **Wheat** – Wheat-based grains such as buns, crackers, pasta, and wheat as an ingredient
☐ **Gluten** – Wheat, rye, barley, and non-certified oats
☐ **Sesame** – Sesame seeds, oil, flour, paste, Tahini
☐ **Alpha Gal Related Food Items –** Pork, Beef, Milk, Milk Products, Gelatin *(circle all that apply)*
☐ **Sweetened Food Items** – cereals, honey, syrups, fruit-flavored yogurt, etc., which may affect blood sugar levels (diabetic diagnosis required)
☐ **Other** - _____

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

Adjustment to meal preparation (i.e. food puree) and /or serving time(s):

Food Management Plan

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

_____

REQUIRED List all acceptable and safe food or beverage substitutes:

_____

_____

Comments: _____

_____

_____

Prescribing Physician/Medical Authority Name PRINTED | **Date** | **Prescribing Physician/Medical Authority SIGNATURE**

FOR FOOD SERVICE USE ONLY (Other information, please see back)

Date Received:	By: (employee signature)
Date Implemented:	By: (employee signature)
☐ Copied for FS Manager	☐ Copied for School Nurse
Other information:	