Diet Modification Request for Foods Served Through
Child Nutrition Programs of Nevada Legacy Traditional Schools

Child's Name: _____ District and/or School/site: _____
Grade: _____ Student ID Number: _____
Parent/Guardian Name: _____ Phone: _____
Email Address: _____

Select one of the boxes that applies to your child's needs:

☐ **YES = Accommodation based on IEP or 504 - To be completed by licensed physician or recognized medical authority (Doctor of Medicine, Doctor of Osteopathy, Physician Assistant, or Advanced Practice Registered Nurse only)**

Federal regulations governing the Child Nutrition Programs provide that schools/districts **must** make substitutions in meals for students who are considered to have a disability as defined by the Americans with Disability Act and whose disability restricts their diet when supported by a statement signed by a physician licensed by the state which includes all information in questions a and b below.

If YES, then the rest of the form does not need to be completed.

Note: The school/district may use the IEP or 504 Plan in lieu of this form and keep on file.

a. **Description of child's physical or mental impairment (must be sufficient to allow school site/district to understand how it restricts child's diet):**

b. **What meal modifications are needed?** (e.g. texture changes and/or food item substitutions, see common allergens)
Must identify any foods to be omitted: | **Must** identify foods to be substituted/added:

☐ **YES = Medical condition, NOT based on IEP or 504 - To be completed by recognized medical authority (Doctor of Medicine, Doctor of Osteopathy, Physician Assistant, or Advanced Practice Registered Nurse only)**

A school/district, **at its discretion**, may make menu substitutions with a signed statement from a recognized medical authority for a student who is requesting a meal modification.

a. **Description of the child's physical or mental impairment (must be sufficient to allow school site/district to understand how it restricts your child's diet):**

b **What meal modifications are needed?** (e.g. texture changes and/or food item substitutions, see common allergens)
Must identify any foods to be omitted | **Must** identify foods to be substituted/added:

Licensed Healthcare Professional Name: _____ Date: _____
Licensed Healthcare Professional Name Signature: _____ Date: _____
Title of Professional: _____Office Phone Number: _____

☐ **YES = I request a substitute for fluid milk for my student.**

A school/district, **at its discretion**, may make **a nutrient equal substitution** with a signed statement from a parent or medical provider for a student who is unable to consume fluid milk for any reasonable request that does not rise to a level of a disability.

Parent/Guardian Signature: _____ Date: _____

This institution is an equal opportunity provider.

Some common allergens with various ways they are found in foods.
Please check the box in front of food groups that should NOT be served:

Lactose/milk – *Do not serve the following checked items:*

- ☐ Fluid Milk to drink or use on cereal
- ☐ Milk based desserts such as: ice cream and pudding
- ☐ Hot entrees with cheese as a prime ingredient such as: grilled cheese, cheese pizza, or macaroni & cheese
- ☐ Cheese baked in products such as: a casserole or on meat pizza
- ☐ Cold cheese such as: string cheese or sliced cheese on a sandwich
- ☐ Milk in products such as: breads, mashed potatoes, cookies or graham crackers

SERVE THESE ITEMS INSTEAD:

Soy - *Do not serve the following checked items*:

- ☐ Protein products extended with soy
- ☐ Processed items cooked in soy oil
- ☐ Food products with soy as an ingredient no matter where on the ingredient list
- ☐ Food products with soy listed as the fourth ingredient or further down the list

SERVE THESE ITEMS INSTEAD:

Egg - *Do not serve the following checked items:*

- ☐ Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold
- ☐ Eggs used in breading or coating of products
- ☐ Baked products with eggs such as breads or desserts

SERVE THESE ITEMS INSTEAD:

Shellfish or fish – *Do not serve the following checked items:*

- ☐ Specific fish or seafood type:_____

SERVE THESE ITEMS INSTEAD:

Peanuts – *Do not serve the following checked items:*

- ☐ Peanuts, individually or as an ingredient
- ☐ Foods containing peanut oil
- ☐ Foods items identified as manufactured in a plant that also handles peanuts

SERVE THESE ITEMS INSTEAD:

Tree nuts – *Do not serve the following checked items:*

- ☐ Specify type(s): _____
- ☐ Foods items identified as manufactured in a plant that also handles nuts

SERVE THESE ITEMS INSTEAD:

Please contact the Legacy Nutrition Coordinator Team at Nutrition@legacytraditional.org or by phone: 1-480-909-4398 with any questions. Return the completed form to the Food Service Department via email food@legacytraditional.org or by Fax at 1-480-393-1757

For Child Nutrition Services Office use only. Date received by Nutrition Coordinator: _____
Is additional clarification needed on the medical statement? ____Yes or____ No. If yes, please indicate follow up date here: _____Initial _____. Date discontinued: _____ (Attach documents)

This institution is an equal opportunity provider.