

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: _____

**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)