Return completed form to:
SCH Food & Nutrition
41 Williams Street
Hammond, IN 46320
OR: SCHLunch@hammond.k12.in.us
OR: Fax: 219-554-4502

School City of Hammond
Department of Food & Nutrition
DIET MODIFICATION REQUEST FORM

Office Use Only:
Received: _____
Mosaic POS: _____
PCS SD: _____

Nutrition and allergen information is available via **MealViewer** to help you plan your child's meals in a way that fits with your dietary and religious preferences. **MealViewer** can be accessed at www.schlunch.com **OR** users can download to any smart device by downloading the '**MealViewer To Go**' app and searching for your school. You can set up a profile for multiple children.

Section I : STUDENT INFORMATION - To be completed by Parent/Guardian

Student ID Number	Students Last Name	Students First Name	MI	Date of Birth

PARENT / GUARDIAN INFORMATION

Name	Phone	Mailing Address, City, State, Zip

E-mail Address (We will use this to send acknowledgement and details of your child´s menú plan. PRINT NEATLY)

Section II : I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Department of Food & Nutrition and the school nurse. I consent to the exchange of information between the physician and school as needed.

PARENT/GUARDIAN SIGNATURE (required for processing) X _____ **DATE** _____

Section III : Does the student have a disability, medical condition, or severe food allergy warranting a special diet? ☐ **Yes** ☐ **No**

A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

If **"YES"**, please check all that apply: ☐ **Food Allergy** ☐ **Food Intolerance** ☐ **Other (explain):** _____

If **"NO"**, a special diet is not warranted.

Food Texture Modifications (only fill out if texture modification is needed):

Is student allowed to have food/drink by mouth? ☐ Yes ☐ No

Food Texture Modifications that are required: ☐ Pureed ☐ Mechanically/Finely Ground ☐ Cut/Chopped into bite sized pieces

Thickened Liquids: ☐ None/Thin ☐ Nectar Thick ☐ Honey Thick

Section IV : Please select all foods to omit from student's diet during the school day (not to be used as a medical history):

Fluid Drinking Milk (ONLY CHOOSE ONE)
- ☐ Fluid Milk (substitute with Lactaid)
  For students who are lactose intolerant
- ☐ Fluid Milk (substitute with soy milk)
  For students with a true milk allergy

Other Milk Products (Select all that apply)
- ☐ Yogurt
- ☐ Cheese (anything with cheese as an ingredient)
- ☐ All menu items with milk/dairy/cheese as an ingredient
  For students with a true milk allergy

Fish or Shellfish (Select all that apply)
- ☐ Fish
- ☐ Shellfish

Peanuts & Tree Nuts (Mark all that apply)
- ☐ Peanuts
- ☐ Tree Nuts specify: _____

Egg
- ☐ Whole eggs (no scrambled eggs or hard boiled eggs)
- ☐ All menu items with egg listed as an ingredient
  this includes baked items

Wheat
- ☐ All menu items with wheat listed as an ingredient

Soy
- ☐ All menu items with soy listed as an ingredient

Other:
- ☐ Other, please specify whether or not it is a cooked ingredient or when consumed fresh (or both)

_____
_____
_____

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/Life Threatening food allergy or food intolerance/allergy as indicated. ☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP** ☐ **SLP**

Name of Medical Authority (PLEASE PRINT)

Prescribing Physician/Medical Authority (SIGNATURE)
X

Contact Number (DATE)

Medical Office Stamp (required for processing)

This institution is an equal opportunity provider.

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DO NOT WRITE IN THIS AREA