

Diet Modifications for Meals for Children or Adults with a Diagnosed Food Allergy or Disability

Name of Child/Adult Participant: _____

Diagnosis of disability or food allergy that requires a diet modification*: _____

Include a brief description of the major life activity affected by the condition: _____

FOODS TO BE OMITTED and SUGGESTED SUBSTITUTIONS:

Please check the food group(s) to be omitted. List specific foods to be omitted and suggest substitutions. Use the back of this form or attach additional information as needed.

<u>FOODS TO OMIT</u>	<u>SUGGESTED SUBSTITUTIONS</u>
<input type="checkbox"/> Milk/Dairy Products _____	_____
<input type="checkbox"/> Eggs/Egg Products _____	_____
<input type="checkbox"/> Wheat/Wheat Products _____	_____
<input type="checkbox"/> Soy/Soy Products _____	_____
<input type="checkbox"/> Peanuts _____	_____
<input type="checkbox"/> Tree Nuts _____	_____
<input type="checkbox"/> Fish _____	_____
<input type="checkbox"/> Shellfish _____	_____
<input type="checkbox"/> Other _____	_____

TEXTURE REQUIRED:

Regular Chopped Ground Pureed

Other detailed information regarding diet or feeding: _____

I certify that the above named individual needs diet modifications as described above because of the specified disability or life-threatening food allergy:

Signature of Physician or Other Licensed Medical Professional Office Phone Date

Printed Name of Physician or Other Licensed Medical Professional

I understand that if medical needs change, it is my responsibility to notify the school/child care/adult day care provider and to submit an updated Diet Modification Form. I give my permission to share the information on this form with the individuals who take part in the care of the above named individual.

Participant/Parent/Guardian's Signature Phone No. Date

*The Americans with Disabilities Act defines *disability* as "a physical or mental impairment that substantially limits one or more major life activities" of an individual.