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
School Year 2021-2022
DIET MODIFICATION REQUEST FORM

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

PART A COMPLETED BY THE PARENT/GUARDIAN

Student ID# *(Número de Estudiante)* | **Student's Last Name** *(Apellido)* | **Student's First Name** *(Nombre del Estudiante)* | **Date of Birth** *(Fecha de Nacimiento)*

School *(Escuela)* | **Grade** *(Grado)*

Meals Eaten at School *(Los alimentos que su niño(a) consumirá en la escuela)*
☐ **Breakfast** *(Desayuno)* ☐ **Lunch** *(Almuerzo)* ☐ **Snack** *(Merienda)* ☐ **None** *(Nada)*

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

Name *(Nombre)* | Phone Number *(Teléfono)* | Mailing Address, City, State, Zip *(Dirección postal, Ciudad, Estado, Código Postal)*

E-mail Address (We will use this to send acknowledgement and details of your child´s menu plan. PRINT NEATLY)
Dirección de correo electrónico (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

Does the student have an identified disability (IEP or 504 Plan)? *¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)?* ☐ IEP ☐ 504 ☐ No

I consent to the exchange of information between the Healthcare Provider and district/school personnel, as needed. *(Doy mi consentimiento para que la información sea entre el médico y la escuela, según sea necesario).* **Parent / Guardian Signature (required for processing)**

Firma del padre/madre/tutor *- requerido para ser procesado* | **Date** *(Fecha)*

Student Condition That Does Not Require Medical Signature:
☐ Lactose Intolerance: Available options to substitute are: ☐ Lactose Free Milk ☐ Soy Milk Mark if the student can eat: ☐ Cheese ☐ Yogurt

PART B COMPLETED BY THE PHYSICIAN / MEDICAL AUTHORITY ONLY

Please select all foods to **OMIT** from student's diet during the school day **due to ALLERGY** (not to be used as a medical history):

DAIRY
- ☐ All food/beverages with milk listed as an ingredient including baked goods
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Yogurt
- ☐ Fluid Milk. Substitute with ☐ Lactose-free milk ☐ soy milk ☐ water

Egg (Select ONLY **ONE**)
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ All menu items with any egg listed as an ingredient

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

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

Wheat / Gluten
- ☐ 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 is a cooked ingredient or when consumed fresh (or both)

_____
_____

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

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

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

Thickened liquids: ☐ None / Thin ☐ Nectar Thick ☐ Noney Thick

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)

Contact Number | **DATE**

Medical Office Stamp (required for processing)

This institution is an equal opportunity provider.

2981394365

DO NOT WRITE IN THIS AREA