MASCHIO'S FOOD ALLERGY MANAGEMENT Program

MEDICAL STATEMENT:
Request for Special Meals and Milk Substitutions

Please email forms to nutrition@maschiofood.com or fax to (908) 888 2335

To Be Completed by Parent/Guardian. Please Print Clearly. **Required**

School District or School Name:	School Site: Grade: Teacher:
Student Name: Preferred Name (if applicable):	☐ Male ☐ Other ☐ Female ☐ Choose not to disclose
Name of Parent/Guardian:	Phone Number: Email:

Signature of Parent / Guardian:_____

The following sections below must be completed by a **licensed medical professional**. *Please Print.*

OR

If updated yearly medical documentation is already on file check here and attach documentation.

(No need to fill out the information below on pages 1 and 2 if documentation is on file) ☐

Requesting Accommodation For:

- ☐ **Life-threatening** (anaphylactic) food allergy
- ☐ **Non-life-threatening** food allergy
- ☐ Celiac Disease or Gluten Intolerance
- ☐ Lactose Intolerance and is requesting a milk substitution **(not for milk allergy)**

  Choice of: ☐ Soy Milk ☐ Lactaid

  ***Note**: Per USDA guidelines, we cannot substitute water for milk
- ☐ Chewing/swallowing disorder and is requesting texture modification
- ☐ For thickened liquids: **Choice of:** ☐ Honey ☐ Nectar ☐ Other: _____
- ☐ Student has diabetes and has a diet order for carbohydrate allowance

  Breakfast_____ (grams) Lunch_____ (grams) Snack_____ (grams)

  (**Please attach a copy of the diet order)**

State disability or medical condition requiring special meal, accommodation or fluid milk substitution (e.g., life-threatening food allergy to peanuts):

_____

Please provide a description of major life activities affected:

_____

Diet prescription or accommodation: (Please describe in detail for appropriate implementation. Attach another sheet if needed):

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The following section must be completed by a **licensed medical professional**.
Please Print.

Foods to be Omitted:	Foods to Substitute:

☐ Student has a special dietary need not listed above **(please explain below)**

Texture Modification
To receive texture modification, a signed diet prescription must be attached. Please indicate modification type and list all foods that require modifications.

A' la carte Snacks and Outside Pizza: * *We recommend that students with life-threatening food allergies avoid purchasing snack items or outside pizza as these are more likely to come into contact with allergens during manufacturing or preparation.*

- ☐ We are allowing our child to purchase or receive outside pizza in the cafeteria
- ☐ We are allowing our child to purchase any snack item sold in the cafeteria
- ☐ We are allowing our child to purchase or receive **BOTH** outside pizza and snack item sold in the cafeteria
- ☐ We are **NOT** allowing our child to purchase or receive any snack item sold in the cafeteria
- ☐ We are allowing our child to purchase the following snack items sold in the cafeteria: ***(List Below)***

_____

Signature of Licensed Medical Professional and Credentials (Required)	**Printed Name:**
Phone Number:	**Date:**
Parent/Guardian Signature (Required)	**Printed Name:**
Phone Number:	**Date:**