KNOX COUNTY SCHOOLS

Medical Request for Meal Modification

Student's Name: _____ **Date of Birth**_____ **Grade Level**: _____

School Name: _____ ☐ **Needs accommodations from the cafeteria** ☐ **Packing meals daily**

I certify that the above named student needs to be offered food substitutions due to a food allergy/intolerance or other medical need as indicated. I give permission to the School Nutrition Department to contact the doctor or other recognized medical authority if clarification is needed on these orders. I understand the cafeteria must follow the Medical Authority's orders. In order for the child to be released from these restrictions, a Parenteral Release Form must be signed. Additionally, I understand that if my child's medical or health needs change, it is my responsibility to provide an updated form to the Food and Nutrition Services office and the school nurse.

_____

PARENT/GUARDIAN SIGNATURE **Date** **Phone Number**

To be completed by Physician/Recognized Medical Authority

Food Allergy or Intolerance

☐ **Milk/Dairy**

☐ No Fluid Dairy Milk ☐No Yogurt ☐No Cheese ☐No Ice Cream

☐ No dairy products or derivatives even BAKED IN products

☐ **Egg Allergy**

☐ No whole eggs

☐ No egg products or derivatives even BAKED IN products

☐ **Corn**

☐ Vegetable only ☐ No products made with corn or its derivatives

Life Threatening Food Allergy: ☐ Yes ☐ No

☐ **Wheat**

☐ **Fish** ☐ **Shellfish**

☐ **Sesame** ☐ **Soy**

☐ **Peanut** ☐ **Tree Nut**

Specify nut type/s, as appropriate_____

☐ Omit foods "processed in nut a facility"

☐ **Other** (Please list): _____

_____

Texture Modification

Solids: ☐ Mechanical Soft & Chopped ☐ Ground & Fork Mashable ☐ Pureed ☐ Other _____

Liquids: ☐ Nectar Thick ☐ Honey Thick ☐ Pudding Thick ☐ Other _____

Therapeutic Diet Order **(Write specifics in space provided)**

☐ Diabetic: _____ ☐ Low Protein/PKU: _____ ☐ Sodium Restriction: _____ ☐ Other: _____

Impairment & Accommodations

This diet order is: ☐ Permanent ☐ Temporary

Please specify the student's medical needs and how this restricts his/her diet. _____

_____

Please indicate what must be done to accommodate the child's diet. **If foods are to be eliminated from the diet, please recommend substitutions.** (if the student is allergic to fluid cows milk, please recommend alternatives such as soy milk, almond milk etc.)

_____

_____

_____

Signature Required- Return to School. School nurse will fax (865-594-1203) or scan (megan.minner@knoxschools.org) form to Nutrition Department. No accommodations can be made until received and processed. **Contact Megan Minner, KCS Dietitian at 865-594-3801 with questions.**

_____

Physician's Printed Name **Physician's Contact Number**

_____

Physician or Recognized Medical Authority's Signature **Date**

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To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

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