KCS | KNOX COUNTY SCHOOLS

Medical Request for Meal Modification

Student's Name: ____ **Date of Birth**______________ **ID #**________________

School Name: ____ **Grade Level**: ______________

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.

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

To be completed by Physician/Recognized Medical Authority

Section A. Food Allergy or Intolerance (foods to be omitted)

Life Threatening Food Allergy: ☐ Yes ☐ No

☐ **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**

☐ No Corn Syrup ☐ No Corn Oil

☐ No products made with corn or its derivatives

☐ **Wheat**

☐ **Fish** ☐ **Shellfish**

☐ **Soy**

☐ **Peanut** ☐ **Tree Nut**

Specify nut type/s, as appropriate____________________

☐ Omit foods "processed in nut a facility"

☐ **Other** (Please list): ________________________________

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Section B. Texture Modification:

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

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

Section C. Therapeutic Diet Order: **(Write specifics in space provided)**

☐ Diabetic: _____________ ☐ Low Protein/PKU: _____________ ☐ Sodium Restriction: _____________ ☐ Other: __________________

Section D. Impairment & Accommodations

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

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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.)

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Signature Required - Scan or fax to school. School nurse will fax (865-594-1203) or scan (megan.minner@knoxschools.org) form to Nutrition Department. No accommodation can be made until form is received and processed. Questions? Contact Megan Minner, KCS Dietitian at 865-594-3801.

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

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

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