Maschio's Food Services, Inc.

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

# Medical Statement:
# Request for Special Meals and Milk Substitutions

| To Be Completed by Parent/Guardian. *Please Print Clearly.* **Required** | |
|---|---|
| School District or School Name: | School Site:<br>Grade:<br>Teacher: |
| Student Name:<br><br>Preferred Name (if applicable): | ☐ Male ☐ Other<br>☐ Female ☐ Choose not to disclose |
| Name of Parent/Guardian: | Phone Number:<br><br>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 Below Information 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

☐ 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)**

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

_____

State disability or medical condition requiring special meal, accommodation or fluid milk substitution (i.e. 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):

_____

| The following section must be completed by a **licensed medical professional**. *Please Print.* | |
|---|---|
| Foods to be Omitted: | Foods to Substitute: |
| | |
| | |

| Texture Modification |
|---|
| To receive texture modification, a signed diet prescription must be attached.<br>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:** |

**For Food and Nutrition Services Use Only**

☐ Approves Request ☐ More Information Needed

Notes: