Meal Modifications at School

Name of Student: _____ **School** _____ **Grade:**_____

Description of Physical or Medical Impairment:

_____

_____

Food Allergies:

Egg Fish Peanut Shellfish Tree Nut Soy Wheat
Milk Lactose intolerance Other _____

Is this condition permanent or temporary? Permanent Temporary
If temporary, please give length of time instructions to be followed with explanation:

_____

_____

Diet Prescription: (Check all that apply)
____ Allergies (Describe) _____
____Other (Describe) _____

Foods Omitted: _____

Substitutions: Specified Substitutions: _____

Other information regarding meal modifications: (Please provide additional information Below or attach to this form.)

I certify that the above-named student needs meal modifications as described because of the student's physical or medical impairment.

_____

Medical Professional's signature Office Phone Number Date

_____

Address

Please return to Tioga Central School Nurse 27 Fifth Avenue Tioga Center, NY 13845