Polk County School Nutrition
Diet Modification Form
Instructions School Year 2024-2025

To request modifications to a school meal, the School Nutrition Department must receive a **Diet Modification Form** completed and signed by a state licensed health care professional. Please return the form to the School Nutrition Manager at your child's school.

A new form is required each school year.

Important Information

The regulations of the National School Lunch and School Breakfast Programs:

- **Require** substitutions to the standard meal requirements for participants who have a disability that restricts their diet.

- **Permit**, but does not require, substitutions for other participants who are not disabled but who are unable to consume foods on the regular menu because of medical and/or other special dietary needs.

A person with a disability is a person who has a physical or mental impairment which substantially limits one or more major life activities, who has a record of such impairment, or is regarded as having such impairment. Major life activities are defined as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working." **A state recognized medical authority who is authorized to write medical prescriptions** can make the determination of whether a student has a disability that restricts his or her diet. Food allergies and conditions such as obesity may or may not meet the criteria of a disability. A physician can assess that the food allergy may result in a severe, life-threatening reaction, or the obesity is severe enough to substantially limit a major life activity.

A school district may, at its discretion, make substitutions for individual students who do not have a disability, but who are unable to consume a food item because of medical or other special dietary needs. Such substitutions may only be made on a case-by-case basis when supported by a diet modification form signed by a recognized medical authority such as a physician, physician's assistant or nurse practitioner and approved by the school nutrition department.

Milk Allergy/Lactose Intolerance

The school nutrition department is only permitted to provide a substitute beverage if it is nutritionally equivalent to milk as defined by USDA. **For lactose intolerant students**: Lactose free milk will only be made available if the request is stated on the Diet Modification Form. Access to drinking water is available in all cafeterias.

Diet Modification Form

2024-2025

Date Received by FNS/Initial:_____

READ CAREFULLY: *ONLY COMPLETE THIS FORM IF YOUR CHILD HAS SPECIAL DIETARY NEEDS*

POLK COUNTY PUBLIC SCHOOLS
SCHOOL NUTRITION

INSTRUCTIONS FOR COMPLETING FORM:

PART A: To be fully completed by a parent requesting menu modifications for a student

PART B: To be completed by physician **ONLY** if you are requesting changes to your child's diet due to food allergies or a medical condition

Return completed form to school cafeteria manager.

Please contact district office if you have questions about completing this form: 863-647-4804 x 3

PART A - Parent/Guardian to complete

School Name:	Grade Level: ___Head Start ___Pre-K ___K-5 ___6-8 ___9-12
Student Name:	Student Date of Birth:
Parent/Guardian Name and Email Address:	Telephone Number:

Parent Request:

_____Lactose Intolerance- my child cannot drink/eat: ___milk ___cheese ___yogurt

_____Religious Preferences -my child cannot eat: _____

_____Medical Condition/Allergy **(PHYSICIAN NEEDS TO COMPLETE PART B)**

_____My Child will not eat school meals. This form is for information purposes only.

Parent/Guardian Signature: X_____ Date: _____

(I consent to the exchange of information between physician and school; check if you **do not** consent _____)

PART B- Completed and signed *BY PHYSICIAN ONLY* - food allergy/medical condition

Special Diet Request due to_____ Food Allergies _____ Medical Condition (please specify)_____

Please check all the foods that need to be **ELIMINATED** from child's diet during the school day; please note life threatening with LF.

DAIRY

_____Fluid Milk (Substitute w/Dairy-Free Milk: **Y**___or **N**___)

_____Cheese _____Cheese cooked in a meal (Pizza,Alfredo)

_____Yogurt

_____Baked goods that contain dairy (Bread)

EGG

_____Whole eggs

_____Baked goods that contain eggs

WHEAT/ GLUTEN

_____Wheat

_____Recipes with any gluten containing grain

FISH OR SHELLFISH

_____Fish _____Shellfish

PEANUTS OR TREE NUTS

_____Peanuts

_____Tree Nuts

CORN

_____Whole corn and corn containing recipes

SOY

_____Soy protein (concentrate, hydrolyzed, isolate)

_____Recipes w/any soy listed as ingredient

OTHER - please specify: _____

TEXTURE - please specify: _____

Specify modified size requirement: _____

Foods to be omitted and recommended alternatives:

X_____

Medical Authority Signature

X_____

Medical Authority Printed Name/Date

Medical Office Stamp (Please include phone number)

For Official Use Only
Date Received by School:_____ Initials:_____
Date Received by SN Manager:_____ Initials:_____

This institution is an equal opportunity provider.

Revised by st 3/34