Gahanna-Jefferson Schools
Child Nutrition and Food Services Department

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School Meals
Food Allergies, Special Diets and Restrictions Form

The USDA School Meals Program requires that ***all questions*** be answered in order for any diet modification or substitution to be made in school meals. Please complete along with your medical professional.

Part A: General Information: To Be Completed by Parent/Guardian

Student Name:_____ Date of Birth:_____ Student ID#_____

School: _____ Grade:_____

Parent/Guardian:_____ Phone:_____

Address:_____ City:_____ Zip: _____

Part B: Life Threatening Food Allergy Medical Professional Statement: To Be Completed by Medical Professional

(If there is NO life threatening food allergy(s), please skip this section and go to Part C-on back).

I declare the student listed above to possess a Life Threatening Food Allergy _____
Medical Professional's Name (Printed)

1. Life threatening food allergy – circle all that must be omitted:

   Milk Wheat Egg Soy Peanut Tree Nut Fish Shellfish

   Other life threatening food allergy, please specify_____

2. Can the student consume food where the allergen is an ingredient in the food product? ___YES ___NO

   (Example: scrambled eggs are omitted but egg as an ingredient in pancake is allowed)

   Additional Detail: _____

   Explanation of why this disability restricts diet: _____

3. Major life activity affected by the life threatening food allergy (check all that apply):

   ___breathing ___operation of major bodily function (immune system, bowel, digestive, etc.)
   ___ Other, specify_____

4. FOODS TO SUBSTITUTE: (If a student cannot drink milk, water with cups are available at every school.)
   _____
   _____
   _____

Medical Professional's Signature: _____Date: _____

Clinic/Facility Name and Address: _____ Phone: _____

Part C: <u>Other Medical or Special Dietary Needs</u> Medical Professional Statement: To be Completed by a Medical Professional (If your child requires a school meal restriction with no substitution, please skip to Part D)

I declare the child listed above to possess a medical or special dietary need: _____
Medical Professional's name (Printed)

1. Specify the medical or special dietary condition: _____
2. Foods to omit:
   _____
   _____
   _____
3. Foods to substitute: (If a student cannot drink milk, water with cups are available at every school.)

   _____
   _____
   _____

Medical Professional's Signature: _____
Clinic/Facility Name and Address
_____

Date: _____ Phone:_____

The USDA nondiscrimination regulation (7 CFR 15 b) as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to regular meals must be made for children who are UNABLE to eat school meals because of their disabilities, when the need is certified by a medical professional.

<u>OFFICE USE</u> Copies to: ___ Nurse _____Food Service Office _____Cafeteria(Alert)

Part D: Dietary Restrictions(Non-Allergy) - Check all that should be omitted from <u>school meals</u> by your student: To be completed by Parent/Guardian

___Liquid Milk (water with cups are available at all schools) ___Wheat ___Whole Eggs
___Foods with eggs baked in ___Soy ____Peanuts ___Tree Nuts ___Fish __Shell Fish
___Dairy Products (cheese, yogurt, ice cream, sour cream)
___Pork ____Pork Gelatin ____Vegetarian
____Other (please specify)

Part E: School Meal Purchasing Restrictions -To be completed by Parent/Guardian: (Ex, May purchase plate lunch only, May purchase snacks with cash only, etc)

_____
_____
_____

Please return this form to your student's school or mail to Gahanna Jefferson Schools Child Nutrition and Food Services Department, 160 S Hamilton Road, Gahanna, OH 43230.