



MASCHIO'S FOOD ALLERGY MANAGEMENT Program

MEDICAL STATEMENT: Request for Special Meals and Milk Substitutions

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

To Be Completed by Parent/Guardian. *Please Print Clearly.* **Required**

School District or School Name:	School Site: Grade: Teacher:
Student Name: Preferred Name (if applicable):	<input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose
Name of Parent/Guardian:	Phone Number: 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 information below 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

For thickened liquids: **Choice of:** Honey Nectar Other: _____

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 (e.g., 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):



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Please Print.

Foods to be Omitted:	Foods to Substitute:

Texture Modification
To receive texture modification, a signed diet prescription must be attached. 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.
<input type="checkbox"/> We are allowing our child to purchase or receive outside pizza in the cafeteria <input type="checkbox"/> We are allowing our child to purchase any snack item sold in the cafeteria <input type="checkbox"/> We are allowing our child to purchase or receive BOTH outside pizza and snack item sold in the cafeteria <input type="checkbox"/> We are NOT allowing our child to purchase or receive any snack item sold in the cafeteria <input type="checkbox"/> We are allowing our child to purchase the following snack items sold in the cafeteria: <div style="text-align: center;">(List Below)</div>

Signature of Licensed Medical Professional and Credentials (Required)	Printed Name:
Phone Number:	Date:
Parent/Guardian Signature (Required)	Printed Name:
Phone Number:	Date:

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