

Food Substitutions or Modifications

Name of Student _____ Age _____

Name of School **Dobyns Bennett High** **Johnson Elementary**
 Robinson Middle **Kennedy Elementary**
 Sevier Middle **Lincoln Elementary** Teacher _____
 Adams Elementary **Roosevelt Elementary**
 Jackson Elementary **Washington Elementary** Grade _____
 Jefferson Elementary **DB Excel @ Cora Cox**

1. Does the child have a disability? **YES** **NO**

Please list: _____

2. Does the disability restrict the child's diet? **YES** **NO**

List reason: _____

3. Please list major life activity affected by the disability: _____

4. Please mark the food allergy or food intolerance (food to be omitted) or list the diet restriction:

Gluten **Wheat** **Other:** _____
 Peanuts **Soy** _____
 Tree nuts **Eggs** _____
 Milk and milk products _____

Provide food or foods that can replace allergens listed above.

Special Instructions: _____

5. Select changes in texture:

Cut up or chopped into bite-sized pieces: _____
 Finely ground: _____
 Pureed: _____
 Other: _____

	Form Received by (School Personnel) / Date: _____
Parent/Guardian Signature / Date	If modifications due to disability, Date of scheduled IEP or 504 Meeting: _____
Provider Signature / Date	***Nothing herein is or should be construed as a warranty, either express or implied, promise, guarantee or such that an individual will not be exposed to allergens. Therefore, it is impossible to guarantee or assure there will be no exposure.
Print Provider Name/Provider Telephone #	

