School Meal Modification Request

This form is intended to provide the Gwinnett County School Nutrition Program some of the medical information necessary to provide modifications to the USDA meal patterns due to a student’s medically necessary nutrition needs/accommodations. The signature of a state licensed medical professional who is authorized write prescriptions is required. Please return the completed form to your school café manager.

Student Name:________________________________________

DOB:_________________  Today’s Date:_________________

School: ___________________________________________________________________________

Medical Diagnosis: __________________________________________________________________

Food Allergies (Circle all that apply):

- Peanuts
- Tree nuts
- Milk
- Soy
- Eggs
- Wheat
- Fish
- Shellfish

Other (please specify):

__________________________________________________________________________________

Special Diet/Food Restrictions (Please specify):

__________________________________________________________________________________

Foods to Avoid:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Doctor’s Name and Address (please print):

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Physician’s Signature  Date  Office Phone Number

Updated: 12 July 2019  “This institution is an equal opportunity provider.”