Diet Modifications for Children or Adults with a Food Allergy or Other Disability*

Name of Child/Adult Participant: ______________________________

Include a brief description of the physical or mental impairment that requires a diet modification:

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FOODS TO BE *OMITTED* and *SUGGESTED SUBSTITUTIONS*:
Please check the food group(s) to be omitted. List specific foods to be omitted and suggest substitutions. Use the back of this form or attach additional information as needed.

FOODS TO OMIT		SUGGESTED SUBSTITUTIONS
☐ Milk/Dairy Products		
☐ Eggs/Egg Products		
☐ Wheat/Wheat Products		
☐ Soy/Soy Products		
☐ Peanuts		
☐ Tree Nuts		
☐ Fish		
☐ Shellfish		
☐ Other		

TEXTURE REQUIRED: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Other detailed information regarding diet or feeding (attach additional information as needed):

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I certify that the above named individual needs diet modifications as described above because of the specified food allergy or other disability*:

Signature of Physician or State Licensed Medical Professional	**Office Phone**	**Date**

Printed Name of Physician or State Licensed Medical Professional

I understand that if medical needs change, it is my responsibility to notify the school/child care/adult day care provider and to submit an updated Diet Modification Form. I give my permission to share the information on this form with the individuals who take part in the care of the above named individual.

Participant/Parent/Guardian's Signature	**Home Phone**	**Date**

*The Americans with Disabilities Act defines *disability* as "a physical or mental impairment that substantially limits one or more major life activities" or bodily functions of an individual.

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This institution is an equal opportunity provider.