Illinois Center for Autism

MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

Please return completed and signed form to ICA Nurse. Phone:618-398-7500, desiree.cole@illinoiscenterforautism.org (FV Campus) , Fax:618-394-9869 lizc@illinoiscenterforautism.org (BLV Campus), Fax:618-234-8146

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student/Client (Last, First): _____Grade:_____

School: _____

Parent/Guardian Email: _____ Daytime Phone: _____

Based on information listed below my child will require a menu modification at the following: ☐ Breakfast ☐ Lunch ☐ Afterschool Snack ☐ Supper ☐ Other _____

I understand it is my responsibility to renew this form each school year and/ or any time my child's medical or health needs change.

_____ _____ _____

Parent/Guardian Name PRINTED | Parent/Guardian SIGNATURE | Date

TO BE COMPLETED BY MEDICAL AUTHORITY (Licensed by State of Illinois to prescribe medication)

The Dietary Needs below are related to (ex: Celiac Disease, Lactose Intolerance, Diabetes, Anaphylactic Food Allergy)

Food To BE OMITTED from diet* (check appropriate boxes below)

- ☐ **Dairy** – Fluid milk, cheese, yogurt, and other dairy ingredients such as casein and whey.
- ☐ **Fluid Milk** – Milk to drink
- ☐ **Peanuts** – Peanuts, Peanut Butter, Peanut oil.
- ☐ **Tree Nuts** – Almonds, hazelnuts, and cashews.
- ☐ **Wheat** – Wheat-based grains such as buns, crackers, pasta, and wheat as an ingredient.
- ☐ **Gluten** – Wheat, rye, barley, and non-certified oats.
- ☐ **Fish** – Fin-fish such as cod and tilapia
- ☐ **Shellfish** – Shrimp and crab
- ☐ **Egg** – Visible egg in a dish such as an omelet
- ☐ **Egg Ingredients** – Egg white, egg yolk or whole egg as an ingredient
- ☐ **Soybean** – Textured Soy Protein, Textured Vegetable Protein, tofu, and whole soybeans (edamame).
- ☐ **Soybean Ingredients** – Soy protein concentrate, soy protein isolate, soy sauce, soy flour, and unrefined soy bean oil
- ☐ **Other** - _____

**Examples of individual food allergens provided are not all-inclusive, other foods may apply.*

Adjustment to meal preparation (i.e. food puree) and /or serving time(s):

Food Management Plan

What are the student's possible reactions/symptoms to the indicated allergen(s) or conditions?

_____

REQUIRED List all acceptable and safe food or beverage substitutes:

_____

_____

Comments: _____

_____

_____ _____ _____

Prescribing Physician/Medical Authority Name Printed | **Date** | **Prescribing Physician/Medical Authority Signature**

FOR FOOD SERVICE NOTES (Other information, please see back)

Date Received:	By: (employee signature)
Date Implemented:	By: (employee signature)
Other information:	