Blessed Sacrament School

MODIFIED MEAL REQUEST BY HEALTH PROFESSIONAL

Please return completed and signed form to Mrs. Amanda Cannon (Kitchen Manager), to acannon@bssmorton.org or drop off in the school office

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (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 School Food Authority is not required to provide requests based on preference for food substitutions or meal accommodations, made by a parent/guardian or any health professional not licensed in Illinois to prescribe medication.

Parent/Guardian Name PRINTED	Parent/Guardian SIGNATURE	Date

MAY BE COMPLETED BY HEALTH PROFESSIONAL
List all foods to be omitted from a student's meal, based upon preference, for medical reasons: (i.e. meal prep/ meal time(s))
Requested substitutions

REQUIRED List all requested food and/or beverage substitutes:

Comments:

Requestor Name Printed	Date	Requestor Signature

TO BE COMPLETED BY FOOD SERVICE STAFF
Date received:
Date implemented: