

MODIFIED MEAL REQUEST BY PARENT/GUARDIAN

Use this form for **NON Medical** reasons for dietary restrictions such as **Gluten Free, Dairy Free, Meat Free, etc. and/or Milk Substitute (Soy)**

Please return completed and signed form to Mrs. Amanda Cannon (Kitchen Manager), to acannon@bssmorton.org or drop off in the 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: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afterschool Snack | | |
| <input type="checkbox"/> Supper <input type="checkbox"/> Other _____ | | |
| <u>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.</u> | | |
| _____ Parent/Guardian Name PRINTED | _____ Parent/Guardian SIGNATURE | _____ Date |

| MAY BE COMPLETED BY PARENT/GUARDIAN OR HEALTH PROFESSIONAL | | |
|--|---------------|------------------------------|
| List all foods to be omitted from a student's meal, based upon preference, NOT for medical reasons: (i.e. meal prep/ meal time(s)) | | |
| | | |
| Requested substitutions | | |
| REQUIRED List all requested <u>food and/or beverage substitutes</u> : | | |
| | | |
| Comments: | | |
| | | |
| _____ Requestor Name Printed | _____ Date | _____ Requestor Signature |

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