

Polk County School Foodservice

Diet Modification Form School Year 2010 – 2011

Please have this form completed and signed by a physician. Return the form to the foodservice manager at your child's school. A new form is required each school year.

Student's Name _____ Date of Birth _____
School _____ Grade _____

Food Allergies/Intolerances	
<input type="checkbox"/> Peanut	<input type="checkbox"/> Gluten
<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Corn
<input type="checkbox"/> Dairy	<input type="checkbox"/> Soy
<input type="checkbox"/> Wheat	<input type="checkbox"/> Egg
<input type="checkbox"/> Oats	<input type="checkbox"/> Fish (Specify)
<input type="checkbox"/> Barley	<input type="checkbox"/> Shellfish
Other:	Other:
Other:	Other:
Comments / Specific Instructions:	

Food Texture Modifications
Please describe texture modification prescribed. Specify which types of foods should be modified and/or omitted.

Signature Required		
Physician Signature	Date	Phone Number