Diet Modification
Form 2025 - 2026

Date Received by FS/Initial: _____

READ CAREFULLY: *ONLY COMPLETE THIS FORM IF YOUR CHILD HAS SPECIAL DIETARY NEEDS*

INSTRUCTIONS FOR COMPLETING FORM:

PART A: To be fully completed by a parent requesting menu modifications for a student

PART B: To be completed by physician **ONLY** if you are requesting changes to your child's diet due to food allergies or a medical condition

Return completed form to school front office.

Please contact district office if you have questions about completing this form: 850-767-1170 or FSSupport@bay.k12.fl.us

PART A - Parent/Guardian to complete

School Name:	Grade Level: ___Pre-K ___K-5 ___6-8 ___9-12
Student Name:	Student Date of Birth:
Parent/Guardian Name and Email Address:	Telephone Number:

Parent Request: _____Medical Condition/Allergy **(PHYSICIAN NEEDS TO COMPLETE PART B)**

_____My Child will not eat school meals. This form is for information purposes only.

Parent/Guardian Signature: X _____ **Date:** _____

PART B- Completed and signed ***BY PHYSICIAN ONLY*** **-** food allergy/medical condition

Special Diet Request due to_____ Food Allergies _____ Medical Condition (please specify)_____

Please check all the foods that need to be **ELIMINATED** from child's diet during the school day; please note life threatening with LF.

DAIRY

_____Fluid Milk (Substitute w/Dairy-Free Milk: **Y**___or **N**___)

_____Cheese _____Cheese cooked in a meal (Pizza, Alfredo)

_____Yogurt

_____Baked goods that contain dairy (Bread)

EGG

_____Whole eggs

_____Baked goods that contain eggs

WHEAT/ GLUTEN

_____Wheat

_____Recipes with any gluten containing grain

FISH OR SHELLFISH

_____Fish _____Shellfish

PEANUTS TREE NUTS

_____Peanuts

_____Tree Nuts

CORN

_____Whole corn and corn containing recipes

SOY

_____Soy protein (concentrate, hydrolyzed, isolate)

_____Recipes w/any soy listed as ingredient

OTHER - please specify: _____

TEXTURE - please specify: _____

Foods to be omitted:	Recommended alternatives:

X_____

Medical Authority Signature

X_____

Medical Authority Printed Name/Date

Medical Office Stamp (Please include phone number)

For Official Use Only
Date Received by School:_____ Initials:_____
Date Received by **Cafeteria** Manager:_____ Initials:_____

This institution is an equal opportunity provider.

Created 06/25