



School Meal Modification Request

This form is intended to provide the Gwinnett County School Nutrition Program some of the medical information necessary to provide modifications to the USDA meal patterns due to a student's medically necessary nutrition needs/accommodations. The signature of a state licensed medical professional who is authorized write prescriptions is required. Please return the completed form to your school café manager.

Student Name: _____

DOB: _____ Today's Date: _____ School: _____

Medical Diagnosis: _____

Food Allergies (Circle all that apply):

Peanuts Tree nuts Milk Soy

Eggs Wheat Fish Shellfish Other (please specify):

Special Diet/Food Restrictions (Please specify):

Foods to Avoid:

Doctor's Name and Address (please print):

Physician's Signature Date Office Phone Number