Special Dietary Needs Request

Baltimore County Public Schools
Food & Nutrition Services
443-809-7855 | OFNS@bcps.org

PARENT/GUARDIAN AUTHORIZATION

Name of Student _____ Date of Birth _____

School Name _____ School Year _____ Grade _____

Parent/Guardian Name *(printed)* _____

Parent/Guardian Email _____

Parent/Guardian Phone Number _____

Milk Substitution Beverage

(May be requested by guardian; medical authorization not needed)

Please substitute the following for dairy milk at all meals:

☐ Soy Milk

I understand that if medical needs change, it is my responsibility to notify the school and to submit an updated Special Dietary Needs Request or Medical Discontinuation Form. I give my permission to share the information on this form with the individuals who take part in the care of the above named individual.

Parent/Guardian Signature _____ **Date** _____

HEALTH CARE PROVIDER AUTHORIZATION

Please have your health care provider complete this section.

1. Select the allergen(s) from the list below that the student should avoid:

☐ **Wheat** ☐ **Soy**
☐ **Peanuts** ☐ **Fish**
☐ **Gluten** ☐ **Sesame**
☐ **Tree Nuts** ☐ **Shellfish**

☐ **Dairy (Allergy or Lactose Intolerance)**
- ☐ Milk baked in products is OK (ex. pancakes)
- ☐ Yogurt is OK ☐ Cheese is OK (ex. pizza)
- ☐ Ice Cream is OK

☐ **Eggs**
- ☐ Eggs baked in products are OK (ex. pancakes)

Other Food Allergies/Intolerances: _____

2. Please indicate if the student has a food allergy that causes anaphylaxis.

☐ Yes, name of food: _____
☐ No

3. Does the student require modified textures? ☐ Yes ☐ No

☐ Pureed ☐ Minced & Moist ☐ Soft & Bite Sized

Does the student require other special dietary needs? If so, please describe below.

_____

I certify that the above named individual requires diet modifications as described above because of the specified food allergy or other disability.

Health Care Provider's Name *(printed)* _____ **Office Phone#** _____

Health Care Provider's Signature _____ **Date** _____

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Procedure

1. **Milk Substitution** requests can be completed by the parent/guardian. These do not require a signature from a healthcare provider.

2. **A Special Dietary Needs** request (i.e. allergy, intolerance), must be completed and signed by a health care provider.

3. **Once completed,** please submit the form to the school nurse. FNS will collaborate with the school nurse to develop appropriate meal modifications and ensure clear communication. *School Nurses Only: Please submit paper request to OFNS@bcps.org.*

4. **If clarification is needed,** FNS staff will contact the parent or guardian directly.

Schools participating in federal child nutrition programs (National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, and Summer Food Service Program) must provide reasonable meal modifications for students whose disabilities restrict their diets, including those with food allergies. Under the Americans with Disabilities Act (ADA), a disability is defined as a physical or mental impairment that substantially limits one or more major life activities or bodily functions.

BCPS Food and Nutrition Services (FNS) collaborates with parents/guardians and school staff to ensure equal access to school meals.

Requests based on religious preferences (e.g., no pork) or lifestyle choices (e.g., vegetarian diets, reduced sugar) are not classified as disabilities and are not required to be accommodated under USDA regulations.

This form may be used independently or in conjunction with a Section 504 Plan.

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