CAFETERIA

School lunches are provided through Archdiocesan School Food and Nutrition Services. The purpose of this program is to provide children with a well-balanced meal. **All elementary school students are required to participate in the lunch program unless there is a diagnosed medical reason. The school must have on file a medical excuse issued by a physician stating the reason for non-participation.**

ALSO, the School Meal Modification Form must be completed and faxed directly from the doctor to Archdiocesan School Food and Nutrition Services.

SCHOOL MEAL MODIFICATION FORM

We do NOT have allergy free kitchens for food prep. Cross-contamination IS a Risk.

Please send COMPLETED Form to Archdiocese of New Orleans SFNS.
Fax: 504-596-3459 Mail: 1000 Howard Ave. Ste. 300, New Orleans 70113 Inquiries: 504-596-3434

Section A: Completion required to prevent delayed processing.

Student Name: _____ Grade: _____ School:_____

Parent/Guardian Name: _____ Phone OR Email:_____

Section B: Completion by MEDICAL AUTHORITY required.

IS THIS STUDENT'S MEDICAL CONDITION A DISABILITY? ____Yes OR ____No

Food Allergies, Intolerances, and Dietary Needs (please mark ALL that apply):

MILK: ____ Beverage* **OR** ____ ALL Dairy* **OR**____ ALL foods*-"May Contain Milk"
*** SUBSTITUTE FOR BEVERAGE MILK (please circle): Juice or Water**

PEANUTS/NUTS: ____ ALL foods- "May Contain/Manufactured Nuts/Peanuts"

SHELLFISH: ____ ALL foods- "May Contain Shellfish"

FISH: ____ ALL foods- "May Contain Fish"

WHEAT: ____ Whole wheat only **OR** ____ ALL foods- "May Contain Wheat"

EGGS: ____ Pure form only (egg white/egg yolk) **OR** ____ ALL foods - "May Contain Egg"

SOY: ____ Pure form only **OR** ____ ALL foods- "May Contain Soy"

CORN: ____ Pure form only (Whole Kernel) **OR** ____ ALL foods- "May Contain Corn"

OTHER ALLERGEN: _____

OTHER SPECIFIC DIETARY NEED: _____

OTHER SPECIFIC OMISSION: _____

SPECIFIC SUBSTITUTION NEEDED: _____

I certify that the above named student has special dietary needs as described above due to the student's medical condition.

Medical Authority Name (print): _____

Medical Authority Telephone Number: _____

Medical Authority Signature and Date: _____