LIMA CITY SCHOOLS
Child Nutrition and Food Services Department
Carrie Woodruff, Food Service Director: cwoodruff@spartan.limacityschools.org
John Music, Food Service Assistant: jmusic@spartan.limacityschools.org

School Meals
Food Allergies, Special Diets and Restrictions Form

The USDA School Meals Program requires that ***all questions*** be answered in order for any diet modification or substitution to be made in school meals. Please complete along with your medical professional.

Part A: General Information: To Be Completed by Parent/Guardian

Student Name:__________________________________ Date of Birth:________________ Student ID#___________

School: ____ Grade:____________

Parent/Guardian:____ Phone:_____________________

Address:____ City:_____________ Zip: _________________

Part B: Life Threatening Food Allergy Medical Professional Statement: To Be Completed by Medical Professional

(If there is NO life threatening food allergy(s), please skip this section and go to Part C-on back).

I declare the student listed above to possess a Life Threatening Food Allergy ________________________________
Medical Professional's Name - PRINTED

1. Life threatening food allergy – circle all that must be omitted:

   Milk Wheat Egg Soy Peanut Tree Nut Fish Shellfish

   Other life threatening food allergy, please specify____

2. Can the student consume food where the allergen is an ingredient in the food product? ___YES ___NO
   (Example: scrambled eggs are omitted but egg as an ingredient in pancake is allowed)
   Additional Detail: ____

   Explanation of why this disability restricts diet: ____

3. Major life activity affected by the life threatening food allergy (check all that apply):

   ___breathing ___operation of major bodily function (immune system, bowel, digestive, etc.) ___ Other, specify____

4. FOODS TO SUBSTITUTE: (If a student cannot drink milk, water with cups are available at every school.)
   ____
   ____

Medical Professional's Signature: ____Date: _______________

Clinic/Facility Name and Address: ____ Phone: _______________

Part C: <u>Other Medical or Special Dietary Needs</u> Medical Professional Statement: To be Completed by a Medical Professional (If your child requires a school meal restriction with no substitution, please skip to Part D)

I declare the child listed above to possess a medical or special dietary need: ______________________________
Medical Professional's name (Printed)

1. Specify the medical or special dietary condition: ____

2. Foods to omit:

____
____
____

3. Foods to substitute: (If a student cannot drink milk, water with cups are available at every school.)

____
____
____

Medical Professional's Signature: ____
Clinic/Facility Name and Address

____

Date: ______________________ Phone:___________________________

The USDA nondiscrimination regulation (7 CFR 15 b) as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to regular meals must be made for children who are UNABLE to eat school meals because of their disabilities, when the need is certified by a medical professional.

<u>OFFICE USE</u> Copies to: ___ Nurse _____Food Service Office ______Cafeteria(Alert)

Please return this form to your student's school or mail to Lima City Schools Child Nutrition and Food Services Department, 755 St. Johns Ave., Lima OH 45804.

 Revised 1/2026