Al-Mamoor School

EST. 2001

Family Food Allergy and Dietary Needs Form

Student dietary information, meal accommodations, family acknowledgment, and healthcare professional instructions

Form owner	School year	Update cycle	Return to
Al-Mamoor School	2026-2027	Annually and whenever needs change	School office or nurse

Al-Mamoor School

Established 2001

Family Food Allergy and Dietary Needs Form

Al-Mamoor School • Confidential student information • 2026-2027

Please complete one form per child and return it to the school office or nurse. Tell us about allergies, medical dietary needs and other meal requests so we can plan safe service. Submit updates whenever needs change. This is a meal planning form and does not authorize medication or replace an emergency action plan.

Student and family information

Student full name _____

Date of birth and grade _____

Parent or guardian name _____

Primary phone and alternate phone _____

Email and preferred language _____

Emergency contact name relationship and phone _____

Meal needs

School meals used: [ ] Breakfast [ ] Lunch
[ ] No known food allergy or dietary restriction at this time
[ ] Food allergy [ ] Intolerance [ ] Other medical dietary need
[ ] Religious dietary request [ ] Vegetarian or other preference

Foods or ingredients to avoid and reason for each:

_____
_____

Suggested foods or drinks your child can have:

_____
_____

Does your child need a special food texture, feeding assistance or modified drink?
[ ] No [ ] Yes Describe: _____
_____

Allergy and emergency information

Check known allergens. Write the exact food where needed.
[ ] Milk [ ] Egg [ ] Peanut [ ] Tree nut type: _____
[ ] Wheat [ ] Soy [ ] Sesame [ ] Fish type: _____
[ ] Shellfish type: _____ [ ] Other: _____

Symptoms or past reactions, including any severe reaction:

_____
_____

Has an emergency allergy action plan been provided? [ ] Yes [ ] No
Is emergency medication prescribed? [ ] Yes [ ] No
If yes, contact the nurse to arrange required medication forms and supplies.

Family acknowledgment and school review

Family acknowledgment

The information I provided is accurate to the best of my knowledge. I will promptly report changes in my child's dietary needs, contact information or medical instructions. I understand the school will contact me to clarify requests and develop meal arrangements. Relevant information may be shared with authorized school staff who need it to provide meals and protect my child's health, consistent with school privacy procedures.

This form is not a waiver of my child's rights or the school's responsibilities. The school will review disability-related meal requests individually. Medical documentation may be requested when needed, including for modifications outside the meal pattern. The school will work with our family on safe interim arrangements while obtaining clarification.

Parent or guardian printed name _____

Parent or guardian signature and date _____

For school use only

Date received and staff member _____

Nurse or health designee review and date _____

Food service manager review and date _____

Request reviewed as: [ ] Disability-related accommodation
[ ] Nonmedical request [ ] Clarification needed
Medical statement: [ ] Attached [ ] Requested [ ] Not needed at this stage
Emergency action plan: [ ] On file [ ] Follow-up needed [ ] Not applicable

Approved meal instructions or interim safe arrangement:

_____
_____
_____

Cross-contact precautions and serving or feeding instructions:

_____
_____

Staff who must receive instructions, including classroom and substitute coverage:

_____

Start date _____ Review date _____
Family notified by _____ Date _____

Food service approval _____ Nurse review _____
Meal changes communicated to assigned staff by _____ Date _____

Keep this form with restricted student records. Provide serving staff only the information needed for the assigned task. Review with the family at least annually and whenever information changes.

Healthcare Professional Meal Modification Statement

Complete when medical documentation is needed for a disability-related meal modification. A statement from a state-licensed healthcare professional authorized to write medical prescriptions under state law, or a registered dietitian, may support the request. A separate signed statement with the same information is acceptable. Do not delay communication about a safe interim meal while this section is completed.

Student name and date of birth _____

Parent or guardian name and phone _____

Medical meal instructions

Describe the physical or mental impairment sufficiently to explain the dietary restriction. A diagnosis is not required if the information adequately explains the need.

_____

_____

How does the impairment restrict the student's diet?

_____

_____

Foods or ingredients to omit, including relevant forms or preparation methods:

_____

_____

Recommended substitutions and amounts if relevant:

_____

_____

Required texture changes, feeding support or other meal precautions:

_____

_____

Expected duration: [ ] Ongoing [ ] Until _____
Recommended review date _____
Emergency action plan needed? [ ] Yes [ ] No [ ] Addressed separately

Physician Information

Name _____

Practice name and phone number _____

Signature and date _____

Medication orders and emergency treatment instructions will provided through the school's separate health procedures. The school will contact the family or professional for clarification when necessary to implement the meal modification.