



2026-2027

SPECIAL MEAL REQUEST FORM FOOD ALLERGY AND SPECIAL DIET PROGRAM (FASDP)



MASCHIO'S MEDICAL STATEMENT: REQUEST FOR SPECIAL MEALS AND MILK SUBSTITUTIONS
To be completed by parent/guardian and signed by licensed medical provider. Please print clearly and email completed form to nutrition@maschiofood.com OR fax to (908) 888-2335. Maschio's Food Services respects your privacy. Health information disclosed in this document will only be shared with individuals who support efforts to provide safe meal modifications.

1. School District Name

If your school is not in a district, please proceed to next question and enter school name.

2. School Name

3. Student's Full Name

(First Name and Last Name)

4. Date of Birth (D.O.B)

5. Grade

6. Teacher's Full Name

(First Name and Last Name)

7. Sex: ☐ Male ☐ Female

8. Do you have additional information you would like to share with us about your child or information that our staff should be aware of?

9. Parent/Guardian's Full Name

(First Name and Last Name)

10. Parent/Guardian's Phone Number

11. Parent/Guardian's Email

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12. Please choose one of the following menus you are requesting:

☐ **Allergen-Safe Menu** (for students with food allergies)

☐ **Special Diet Menu** (for students who require a special diet for a medical condition like diabetes, phenylketonuria "PKU," kidney disease, etc.)

13. Is this the first time you are requesting an allergen-safe or special diet menu from Maschio's Food Services?

☐ Yes ☐ No

14. Did your child have an allergen-safe or special diet menu in the previous school year?

☐ **Yes** Updated medical forms must be submitted to the nutrition department annually as these menus do not rollover year to year. Please complete the following sections in entirety. Please email additional medical documentation to nutrition@maschiofood.com or fax (908) 888-2335.

☐ No

REQUEST FOR ALLERGEN-SAFE MENU

Please check all that apply.

15. ☐ **Life-threatening (Anaphylactic) Food Allergy**

☐ **Non-life-threatening food allergy**

☐ Dairy

☐ Shellfish

☐ Non Celiac Gluten Sensitivity

☐ Egg

☐ Fish

☐ Alpha Gal Syndrome

☐ Tree Nuts

☐ Sesame

☐ Food Protein-Induced Enterocolitis Syndrome (FPIES)

☐ Peanuts

☐ **Lactose Intolerance** (avoidance of milk, cheese, yogurt but not a milk allergy)

☐ Eosinophilic Esophagitis (EoE)

☐ Soy

☐ Wheat

☐ Celiac Disease

Other: _____

16. If your child is lactose intolerant (milk substitution only), which of the following would you like? *Please note selection is based upon availability.

☐ Soy Milk

☐ Lactose-Free Milk

☐ Ripple Milk (pea protein-based milk)

☐ Oat Milk

☐ Rice Milk

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REQUEST FOR SPECIAL DIET MENU

Please check all that apply.

17. ☐ Type I or Type II Diabetes
- ☐ Student has diabetes and has a diet order for carbohydrate allowance.
Please provide grams of carbohydrates per meal:
- Breakfast: _____ (grams)
- Lunch: _____ (grams)
- After School Snack: _____ (grams)
- ☐ Phenylketonuria ("PKU")
- ☐ Kidney Disease
- ☐ Other: _____
- ☐ Texture Modification

TEXTURE MODIFICATIONS: IDDSI FRAMEWORK

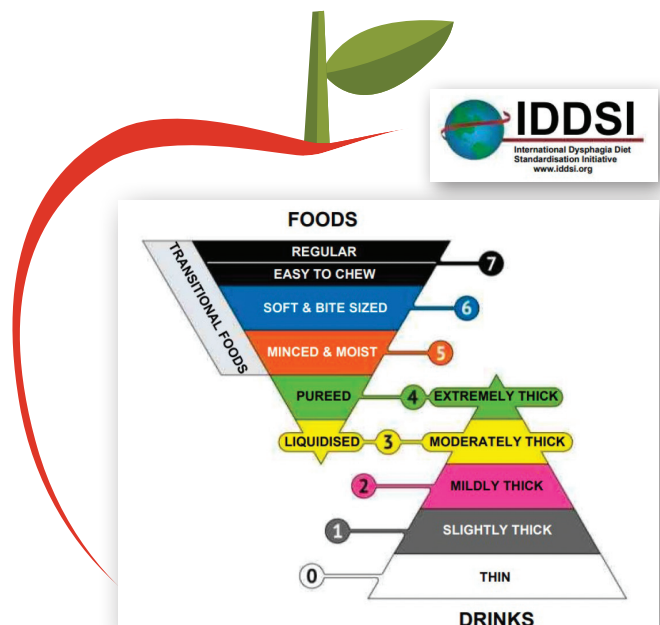
Please check all that apply. Please reference the IDDSI framework on the right side to answer the following questions.

18. What IDDSI standard is being followed for food?

- ☐ 7: Easy to Chew
- ☐ 6: Soft and Bite-Sized
- ☐ 5: Minced and Moist
- ☐ 4: Pureed

19. What IDDSI standard is being followed for liquid?

- ☐ 4: Extremely Thick
- ☐ 3: Moderately Thick
- ☐ 2: Mildly Thick
- ☐ 1: Slightly Thick





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20. Please provide a description of major life activities affected:

21. Name of Child's Licensed Medical Provider: _____

22. Name of Licensed Medical Provider's Practice and Address:

23. Licensed Medical Provider's Phone Number: _____

À LA CARTE

We highly recommend that students with food allergies avoid purchasing snacks sold during school hours as these snacks are more likely to come into contact with allergens during manufacturing or preparation.

24. ☐ We are allowing our child to obtain snacks sold during school hours.

☐ We are NOT allowing our child to obtain snacks sold during school hours.

Name of Parent/Guardian

Name of Licensed Medical Provider

Signature

Signature of Licensed Medical Provider

Date

Date