



POCONO MOUNTAIN SCHOOL DISTRICT

PO Box 200 • Swiftwater, PA 18370 • 570-839-7121

For Office Use:

Initials

Child Nutrition Department Special Diet Form 2025 - 2026

Part 1 - Parent/Guardian to complete the following

Today's Date:

Students Name:

Student ID#:

Name of School:

Grade:

DOB:

Which meals will the student be eating from the cafeteria? Circle ALL that apply: Breakfast - Lunch - None

Parent/Guardian Name:

Good Email to Contact:

Phone #:

Part 2 - To be completed by a Licensed Physician, Physician's Assistant, or Registered Nurse Practitioner

A) Does this student have a severe or life-threatening food allergy, identified disability, or medical condition? The school may choose to accommodate a student with a non-disabling special dietary need.

- NO
- YES - Specify affected life activities below.

B) Describe condition(s): _____

C) Indicate Food Allergy(s) or Food(s) to be Avoided:

- Lactose Intolerance - Fluid milk only
- Lactose Intolerance - Fluid milk, yogurt, & cheese (ex. Pizza)
- Milk (MILD Allergy) - Fluid milk only
- Milk (MILD Allergy) - Dairy & dairy products
- Milk - Dairy, dairy products, & foods with milk ingredients (ex. Muffins, Rice Krispies Treats)
- Soybean - Whole soybeans, textured soy protein, & tofu
- Soybean ingredients- Soybean oil & soy lecithin
- Eggs - Whole eggs (ex. Boiled, scrambled)
- Egg ingredients - Eggs cooked into foods (ex. Pancakes)
- Wheat/Gluten - Celiac Disease
- Sesame
- Peanuts
- Tree Nuts
- Fish
- Shellfish

Other: _____

D) May this student have foods that are made in the same facility as any of their allergens (trace amounts)?

- YES
- NO - Specify which allergens: _____

E) Suggested substitutions for food items not served (Note: Water & juice cannot be substituted for milk in cases of a non-disability per USDA. The district offers lactaid milk & soymilk as milk substitutes.):

Medical Authority Credential

Medical Authority Signature

Date

Office Phone #

Email or Fax to

mmazaika@pmsd.org or (570)839-3133