Food Allergy/Disability Substitution Request
2009 - 2010

Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability: _____ Allergy: _____

FOOD ALLERGY

Please indicate your child's special needs below:

☐ Diabetic* ☐ Lactose-Free ☐ Peanut Allergy ☐ Other: _____

_____

***FOR DIABETIC ONLY: Menu selections must be made on the school calendar menu per doctor's orders/individual health plan.**

FOR USE BY PHYSICIAN ONLY

Non-Allowable Food	may be substituted with	**Allowable Food***
_____		_____
_____		_____
_____		_____
_____		_____

*NOTE: The Child Nutrition Services department will attempt to accommodate the substitutions as requested, but reserves the right to modify the menu based on product availability.

I certify that the above named student needs to be offered food substitutes as described above because of the student's medical allergy or disability indicated above.

_____ _____
Name of Physician Phone

_____ _____
Signature of Physician ***(Required)*** Date

I understand that if my child's medical or health needs change, it is my responsibility to notify the school office.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Address of Parent/Guardian Contact Number of Parent/Guardian

Original to: ☐ Child Nutrition Department Copies to: ☐ Campus Nurse ☐ Campus Café File

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