Child Nutrition Program

Food Allergy/Disability Substitution Request

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(s)*
_____		_____
_____		_____
_____		_____
_____		_____

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. (Use back of form if needed.)

_____ _____

Name of Physician Telephone Number

_____ _____

Signature of Physician **(Required)** Date

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

_____ _____

Signature of Parent/Guardian Date

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

Copies to: ☐ **Nurse** ☐ **Child Nutrition Office** ☐ **Campus File**

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