

**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.**

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 <b>(Required)</b>	Date

**FOR USE BY PHYSICIAN ONLY**

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
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**\*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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