District Offices at Marion High School
750 W. 26th St., Marion, IN 46953
ph: 662-2546

CHILD NUTRITION PROGRAM
FOOD ALLERGY/DISABILITY PHYSICIAN DOCUMENTATION FORM

Student's name: ______________________ Age: ____ Grade: ____ School: ______________

Allergy: ______________________________________ Disability? ☐ YES ☐ NO

Describe the reaction: ____

____

____

Severity: ☐ MILD ☐ LIFE-THREATENING

Please indicate child's special needs below:

☐ Diabetic* ☐ Lactose-free ☐ Peanut allergy ☐ Other (explain): ______________________

**For diabetic only: Menu selections must be made on the school calendar menu per doctor's orders/individual health plan.*

FOR PHYSICIAN USE ONLY

Non-allowable food	> *may be substituted with* >	Allowable food

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 Telephone number

______________________________ ______________________________

Signature of physician (REQUIRED) 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: ☐ School nurse ☐ Cafeteria supervisor

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