

**Rochester School Corporation Food and Nutrition Services  
Food Allergy/Disability Substitution Request**

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Disability: \_\_\_\_\_ Allergy: \_\_\_\_\_

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**Food Allergy**

Please indicate your child's special needs below:

Diabetic\*  Lactose Free  Peanut Allergy  Other: \_\_\_\_\_

**Doctor's prescription /individual health plan. Physician use only**

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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 _____
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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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