

**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 (Required) _____	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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