



3500 Fairfield Avenue
Shreveport, LA 71104
(318) 219-7297
Fax (318) 868-5057

Allergy/Food Restrictions Form

Student's Name _____ Age _____

School _____ Grade/Classroom _____

Parent's Name _____

Address _____ Telephone (____) _____
(Street or P. O. Box)

City _____ State _____

Please describe foods to be restricted at meal times.

I certify that the above named student has special medical condition(s) and listed are foods to be avoided at school meal times.

Parent Name (Please Print) _____

Parent Signature _____ Date _____

*Optional

Parents may opt to verify the above mentioned food restrictions by a certified medical authority.

_____ *Office Phone # _____

*Office Address

_____ *Licensed Physician/Recognized Medical Authority Signature _____ Date _____

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