DIOCESE OF SHREVEPORT
Child Nutrition Program
Healthy Tools to Help at School

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