

Allergy/Food Restrictions Form

Student's Name _____ Age _____

School _____ Grade/Classroom _____

Parent's Name _____

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

City _____ State _____

Does the student have a disability that requires a special diet modification? Yes _____ No _____

Diet Prescription (Check all that apply.):

- ____ Diabetic
 ____ Food Allergy
 ____ Hypoglycemic
 ____ Other _____

Foods Omitted and Substitutions: *Please identify specific foods to omit and list foods to be substituted.*

Specific Foods to Omit

Specific Foods to Substitute

I certify that the above-named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Office Address _____ Office Telephone # () _____

¹Licensed Physician/Recognized Medical Authority Signature

 Date

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