Port Neches-Groves Independent School District – Child Nutrition Department
Food Allergy/Disability Substitution Request

This form will be kept on file at the individual school site.
Your doctor's office must complete this form before any food substitutions will be made.

Student's Name:______________________ Age: _________________________

School: ______________________________ Grade: ________________________

DISABILITY/FOOD ALLERGY

Please indicate your child's special needs below:

Diabetes* 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.*

THIS SECTION FOR USE BY PHYSICIAN ONLY

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 the student's medical allergy or disability indicated above.

_______________________________ _______________________________
Name of Physician Telephone Number

_______________________________ _______________________________
Signature of Physician (Required) Date

I understand that if my child's medical or health needs change, it is my responsibility to notify the school.

_______________________________ _______________________________
Signature of Parent/Guardian Date

**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.*

For questions call (409)962-1017 x 5550