CURRENT SCHOOL YEAR

_____

WAKULLA COUNTY SCHOOL BOARD
FOOD SERVICE DEPARTMENT
DIET MODIFICATION REQUEST

THIS FORM MUST BE SIGNED BY A PHYSICIAN

I. Physician's Name _____ Phone Number _____

II. Student's Name _____ School _____

III. State medical contition that restricts diet:

_____
_____
_____

IV. State specific foods to be omitted from diet:

_____
_____
_____

V. Can the food item(s) be consumed in cooked or processed foods? Yes_____ No_____

VI. List specific foods to be used as a substitution: (Fereral guidelines allow only lactose free milk or soy milk to be substituted for lactose intolerance).

_____
_____
_____

VII. Describe the allergic reaction: _____
_____

VIII. *Certification Statement:*
I certify that the above diet modification is due to a medical condition that is:
_____ *Life Threatening* _____ *Non-life threatening*

Physician's Signature _____

IX. For diet modification to be considered, I authorize the release of medical information specific to this condition to school adminitrators, health aides, and food service personnel.

Parent Signature: _____ Date:_____

This form is reauired for the school district to accommodate dietary modifications and must be on file in the school cafeteria. Accomodations for dietary modifications will be determined case by case.