

**Child Nutrition Program
Food Allergy/Disability Substitution Request**

Student's Name: _____ Age: _____
School: _____ Grade: _____
Disability: _____ Allergy: _____

Food Allergy

Please indicate your child's special needs below:

☐ Diabetic* ☐ 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.**

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 of the student's medical allergy or disability indicated above. (Use back of form if needed.)

Name of Physician

Telephone Number

Signature of Physician **(Required)**

Date

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

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.**

Copies to: ☐ Nurse ☐ Child Nutrition Office ☐ Campus File