Calallen ISD Child Nutrition Department

FOOD ALLERGY or Medical Dietary SUBSTITUTION REQUEST

A doctor's signature is required for all meal substitution requests.

RETURN FORM TO THE NURSE'S OFFICE

Student's name:_____

Birthday:_____

School:_____ Grade:_____

Food
Allergy:_____

Dietary medical concern: please indicate student's special needs below.

___diabetic ___Lactose free ___peanut allergy other_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN ONLY

NON-ALLOWABLE FOOD	ALLOWABLE FOODS (may substitute with)
_____	_____
_____	_____
_____	_____

I certify that the above named student needs to be offered food substitutes as described above because of the student's food allergy or dietary disability indicated above.

_____ _____
Name of Physician Phone number

_____ _____

SIGNATURE OF PHYSICIAN –REQUIRED DATE

I understand that if my child's dietary 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.**

Revised 5/6/2013