

Food Management Plan

What are the student's possible reactions/symptoms to the indicated allergen(s) or conditions?

____ **REQUIRED** List all acceptable and safe food or beverage substitutes:

____ Comments:

Prescribing Physician/Medical Authority Name PRINTED Date Prescribing Physician/Medical Authority SIGNATURE

FOR FOOD SERVICE USE ONLY (Other information, please see back)

Date Received: By: (employee signature)

Date Implemented: By: (employee signature)

Copied for FS Manager Copied for School Nurse

Other information: