

Food Allergy Evaluation and Substitution Form

To be completed by treating physician

Student's name	Age
Name of School	Grade
	Classroom
1. Does the child have a life threatening allergy	___ YES ___ NO
2. If yes, please describe the major life activity affected by the allergy. <i>Examples of these include: eating, breathing, walking, speaking...</i>	
3. Does the student require substitutions or modifications to the normal school meals?	___ YES ___ NO

IF YES, please have your Physician complete the form in its entirety.

IF NO, please sign and send back to your school nurse.

List Allergen(s)	List Foods to be Omitted	List Foods to be Replaced (Brands, Store)

Please list any supplemental feeding necessary:

Contact Information:

Parent or Guardian _____ Telephone _____

Parent Signature _____ Date _____

Physician or Medical Authority Signature: _____ Date _____

Date form received by school _____