Lebanon R-III School District
Medical Statement for Students Requiring Special Meals

Name of Student:	**School Attending:**
Date of Birth :	**Phone #:**
Parent/Guardian Name :	

If special meals are needed and requested, certification from a medical doctor must (1) verify that special meals are needed because of a diagnosis , and (2) prescribe the alternate foods and forms needed._____
_____

2. Why /How does handicap/diagnosis restrict the student's diet?_____

Food Intolerance:_____

Food Allergy:_____
Type of reaction to food: i.e., hives, GI distress, possible anaphylaxis, other- please identify:
_____
Is the food allergy life-threatening (anaphylaxis)? __yes __no
Which specific food(s) cause anaphylaxis?_____

Food(s) to be omitted from Student's Diet:	**YES**	**Food(s) to be substituted:**
Milk: liquid		
Milk: whey or casein protein allergy		
Is milk baked into foods OK?		
Dairy Products: yogurt, cheese, other – please specify:		
Eggs: Soft Scrambled, fresh cooked, raw – please specify:		
Are eggs baked into foods OK?		
Meat/meat alternates – please specify:		
Grains, grain products, gluten – please specify:		
If gluten: is this an intolerance or due to Celiac Disease?		
Fruits, vegetables, please specify:		
Peanuts, tree nuts, all nuts, please specify:		
Other Dietary Information/Instructions:		

_____ _____
Physician's Signature **Date**

_____
Address City State Zip Phone Fax
Will your child consume school meals? Daily_____ Sometimes_____Rarely_____Never_____

PARENT SIGNATURE: _____ DATE: _____
***Above signature by parent/guardian to also serve as authorization to discuss diagnosis/health with authorizing physician. After completion please return to the school nurse .**