

Medical Statement for Student Requiring Special Meals Due to Food Allergy or Intolerance

Student Name: _____

District: _____

Birth Date: _____

School: _____

Parent Name: _____

School Contact: _____

Address: _____

School Address: _____

Phone: _____

School Phone: _____

To be completed by a recognized medical authority (i.e. a licensed physician, physician's assistant or nurse practitioner)

The school is not required to provide substitutions for an allergy or food intolerance, and is permitted to do so **ONLY** when omitted foods and appropriate substitutions are specified by a medical authority. If diet modifications are implemented by the school, they will continue until a medical authority specifies that they should be changed or stopped. Parents/guardians are asked to annually request updated instructions for diet modifications from a medical authority.

- Student has a disability affecting the diet that meets the definition of "disability" as described on the reverse side of this form. If yes, complete Medical Statement for Student Requiring Special Meals Due to Disability.

Diet Prescription (check all that apply):

- Milk/Dairy Products Allergy – No fluid cow's milk or any other food product made with cow's milk such as cheese, yogurt, dried milk powder, etc. * * * If student has intolerance to milk and/or milk products, then please complete Form 21-G, Request to Omit Fluid Cow's Milk.
- Other (describe): _____
- Food allergies – Please check appropriate box(es): ingestion contact inhalation

List the specific food(s) to be omitted and food(s) that may be substituted. If more space is needed for omitted foods or substitutions, please continue on reverse side of form. Specific foods to be omitted and specific foods to be substituted must be listed below or this statement will be returned to the physician/medical authority for clarification.

Meal Modification Start Date: _____

End Date: _____

Omit Foods Listed Below:

Substitute Foods Listed Below:

Statement for Student Requiring Special Meals Due to Food Allergies or Intolerances (continued)

Comments:

Physician/Medical Authority's Certification:

I certify that the student named on this form needs the prescribed food and/or beverage omission(s) and substitution(s) due to his/her food allergy (ies) and/or food intolerance(s).

Medical Authority's Printed Name

Medical Authority's Signature

Phone Number

Date

Preparer or Other Contact's Signature

Phone Number

Date

Parent/Guardian's Consent

I hereby give permission for the school staff to make the prescribed food and/or beverage omission(s) and substitution(s) in my child's school meals. Furthermore, should the school staff require additional information to clarify how to carry out the diet prescription or food omissions and substitutions; I hereby give permission for my child's physician/medical authority to provide any additional information necessary to clarify the diet prescription written on this form.

Parent/Guardian's Signature

Phone Number

Date