Frisco ISD Child Nutrition Programs

# Food Allergy/Disability Substitution Request
# 2009 - 2010

Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability: _____ Allergy: _____

**FOOD ALLERGY**

Please indicate your child's special needs below:

☐ Diabetic* ☐ Lactose Free ☐ Peanut Allergy ☐ Other: _____

_____

***FOR DIABETIC ONLY: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.**

**FOR USE BY PHYSICIAN ONLY**

| **Non Allowable Food** | may be substituted with | **Allowable Food*** |
|---|---|---|
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |

***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. For milk allergies, bottled water or juice may be substituted in place of milk.**

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

_____ _____

Name of Physician Telephone Number

_____ _____

Signature of Physician **(*Required)*** Date

I understand that if my child's medical or health needs change, it is my responsibility to notify the school office.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Address of Parent/Guardian Contact Number of Parent/Guardian

**Original to:** ☐ **Child Nutrition Programs Office** **Copies to:** ☐ **Campus Nurse** ☐ **Campus Café File**

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