INFORMATION CARD

Place child's picture here

Student's Name _____

Teacher's Name _____

Dietary Restrictions/Special Diet _____

Food Allergies/Intolerances _____

Food Substitutions _____

Other Diet Modifications _____

_____

Supplemental Feedings (snacks) _____

Physician/Medical Authority Documentation received (Name, telephone, date)

_____

_____

Additional Contacts (R.D., etc.) Include name and telephone number

_____

_____

Person completing form _____

_____

Date

Medical Statement
for a Child With a Life-Threatening Food Allergy
Requiring Special Foods in Child Nutrition Program

Part I (to be completed by parent/guardian)

Name of Student:	Date of Birth:
Name of Parent/Guardian:	Telephone:
School:	Grade/Unit:

Part II (to be completed and signed by the child's physician)

The above named student has the following life-threatening food allergy/allergies:

Major life activities affected by this disability are:

List food(s) to be omitted from diet:

List food(s) that may be substituted (Diet Plan) and any modifications of texture or consistency that are necessary:

Date

Physician Signature/Phone