Special Dietary Needs Request for Food Allergy / Intolerance Revised 5/15/2015

Submit completed form to Food Services

STUDENT: _____ Birthday: _____ School: _____ Grade/Class:_____

Indicate the food(s) the child is intolerant of or allergic to:

Milk	Eggs (all forms)	Soy
All dairy	Eggs in baked	Fish
Peanuts	goods etc.	Shell Fish
Tree Nuts		Other_____

if exposed by (check all that apply)

eating inhaling skin contact

Check what happens if the child is exposed to the food.

Itching, tingling of mouth, lips etc	Tightness of throat, hoarseness, hacking cough
Swelling of lips, tongue, mouth or face	Shortness of breath, repetitive coughing, wheezing
Hives, itchy rash, swelling	Fainting, pale, blue, weak or thready pulse,
Abdominal cramps, nausea, vomiting, diarrhea	Other _____

PARENT/GUARDIAN CONSENT:

- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this request and the child's disability. Physician's Name: _____
- I give permission to have my child's photo displayed on this form.
- I give consent for this information to be shared with relevant staff.

My signature indicates that I have fully read and understand the above information.

_____ _____ _____ _____

Signature of Parent/Legal Guardian Telephone Home Business Phone Date

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Physician Order: required if the student has a disability related to the food intolerance / allergy**.**

Does the child have a disability (as defined by Section 504 of the Rehabilitation Act or Part B of IDEA)?

Food Anaphylaxis (intolerance is not a disability)

Other disability_____

No disability (Please sign the form and return it. Do not complete the remaining questions.)

What major life activities are affected by the disability?

Caring for one's self	Walking	Breathing
Eating	Seeing	Learning
Performing manual tasks	Hearing	Working
	Speaking	

Why does the disability restrict the child's diet? _____

Foods to be omitted or substituted:

Allergy - avoid the allergen _____

Substitute to be used _____

Lactose Intolerance ___No milk to drink ____No dairy products

PHYSICIAN ORDER:

I confirm the information provided above by the parent. I agree to communicate with school personnel about this dietary request and the related disability.

Physician Name:_____ Fax #: _____

Address:_____ Clinic:_____ Phone #: _____

Physician Signature: _____ Date: _____