Dietary/Food Allergy ~ Action Plan

Requesting Special Foods in Child Nutrition Programs

Medical Statement for Student without a disability

Student's Name:_____ Date of Birth:_____

Student's Teacher:_____ Grade:_____

Name of Parent/Guardian:_____ Relationship:_____

Contact Ph. Number(s): 1st_____ 2nd _____ 3rd _____

I am in agreement with the information listed below which was completed by my physician's office.

✖ _____ _____

Parent's Signature Date

Following to be completed by the Physician's Office:

Description of child's medical or other special dietary needs that restrict the child's diet:

_____

Foods to Omit:_____

Foods to Substitute:_____

Dairy Allergy – my child cannot: ☐ Drink Milk ☐ have any products with Milk

Egg Allergy – my child cannot: ☐ Eat any Eggs ☐ have any products with Eggs

Nut Allergy – my child cannot: ☐ Eat any Peanuts ☐ Eat any Tree nuts

☐ Eat any products that were processed in a facility with nuts

Nut Allergy – Special Seating at a "Peanut Free" table (if nothing is marked, it will be assumed that no special seating is required)

☐ Yes, my child should be seated at a "Peanut Free" table

☐ No, my child can sit at a regular table.

Other Information regarding diet or feeding: (can provide additional information below, on back of form, or attach to this form, if needed).

_____

_____

*Information can be faxed to Ida Elementary School at (734) 269-3885

✖ _____ _____ _____

(REQUIRED) - Physician's Signature Date Office Phone Number