

# *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): 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

*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

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