Food Allergy Medical Statement

requiring special meals in the U.S. Department of Agriculture Child Nutrition Programs (National School Lunch Program, School Breakfast Program, After-School Snack Program, Summer Food Service Program)

Return this form to your child's school. This form, **along with the Health Services Plan**, must be filled out completely and submitted before any meal substitutions can be made for children who have allergies or other disabilities. A new form must be submitted each year, and any midyear changes require the submission of a new form signed by the child's physician.

Part 1-- to be completed by parent/guardian. Please print

Student ID | Student's First Name | Student's Last Name

Student's date of birth (__/__/____) | School

Parent/guardian's name | Email Address

Work Phone (___) ___-____ | Cell Phone (___) ___-____ | Home Phone (___) ___-____

Part 2-- to be completed by licensed physician (physician's assistant or nurse practitioner). Please print.

▶ This student has a **life-threatening food allergy** to : *Please check all that apply*

If Milk, Egg, Soy or Wheat is checked, can this allergen be used as an ingredient (i.e. baked in)?

○ **Peanuts**	○ **Milk**	○ Yes	○ No
○ **Tree nuts**	○ **Eggs**	○ Yes	○ No
○ **Fish**	○ **Soy**	○ Yes	○ No
○ **Shellfish**	○ **Wheat**	○ Yes	○ No

○ **Other-** please specify

If substitution is necessary for above allergy, please list the approved substitution (i.e. if the student has a life-threatening allergy to milk, indicate whether the student should receive juice or water in place of milk):

Food Modification: List modifications of food texture or consistency that are necessary (describe the patient's disability, major life activity affected by the disability and **approved substitution/modification** if any)

▶ This student has a **non-life-threatening food allergy** to (please specify)

Does this non-life-threatening allergy restrict the individual's diet? ○ Yes ○ No
List foods to be omitted from diet and list any **approved substitutions** for those foods:

▶ This Student is **Lactose Intolerant.** ○ Yes ○ No May the student have lactose free milk? ○ Yes ○ No

Note: The only substitution available for lactose intolerance is lactose-free milk

LHP's name _____ Office phone (___) _____
Fax Number (___) _____

LHP's signature _____ Date _____

LHP - Licensed Health provider - licensed physician, physician's assistant or nurse practitioner

This institution is an equal opportunity provider.