CERTIFICATION OF DISABILITY

For Special Dietary Needs

Special Dietary Needs / Allergy Form

Student Name: _____ Date of Birth: _____

Grade: _____

Parent/Guardian Name: _____ Phone Number:

_____

Address: _____

Medical Information (to be completed by a licensed physician)

Diagnosis/Condition (food allergy, intolerance, or medical need):

Food(s) to be omitted from the child's diet:

Nature of reaction (life-threatening, gastrointestinal, skin, other):

Substitute food(s) or modifications required:

Additional instructions, emergency care, or precautions:

Physician's Statement

Physician's Name (Print): _____

Phone Number: _____

Office/Clinic: _____

Physician's Signature: _____

Date: _____

Parent/Guardian Consent

I give permission for school staff to follow the above dietary instructions for my child. I understand it is

my responsibility to provide updated medical documentation if changes occur.

Parent/Guardian Signature: _____ Date: _____

Relates to School Board Policy 4.50