River Road ISD Food Allergy Management Program

FOOD ALLERGY SUBSTITUTION REQUEST

Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability (if any)_____

FOOD ALLERGY Severe or life-threatening (anaphylactic) reaction

Define allegy:_____

_____

*This section to be completed by **Physician only**:*

List of foods not allowed:	**List of foods to be substituted for foods not allowed:**
1. _____	**1.** _____
2. _____	**2.** _____
3. _____	**3.** _____

I certify that the above student needs to be offered food substitutes as described above:

Physician's Name: _____

Office Phone Number: _____

_____ _____

Signature of Physician Date

I understand that if my child's medical or health needs change, it is my responsibility to notify the school office. This request will remain in effect until the school receives ***written*** notification from the parent/guardian.

_____ _____

Signature of Parent/Guardian Date

Copies to: ☐ SCHOOL NURSE ☐ CAFETERIA MANAGER ☐ CAMPUS OFFICE

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(Revised June 2013)