Milford ISD Child Nutrition Program

Food Allergy/Disability Substitution Request

Students Name:_____ Age:_____

School:_____Milford ISD _____Grade:_____

Food Allergy/Special Nutritional or Feeding Needs

Please indicate your Childs special needs below:

- Diabetic
- Lactose Free
- Peanut allergy
- Other: _____

*__FOR DIABETIC ONLY: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.__

FOR USE BY PHYSICIAN ONLY

Non allowable Food	May be substituted with	Allowable Food (s)
_____		_____
_____		_____
_____		_____

I certify that the above names student needs to be offered food substitutes as described above because of the student's medical allergy or disability indicated above. (Use back of form if needed)

_____ _____

Name of Physician Phone number

_____ _____

Signature of Pysicaian **(REQUIRED)** Date

I understand that if my child's medical or health form needs to be changed, it is my responsibility to notify the school nutrition department.

_____ _____

Signature of Parent/Guardian Date

_____

Daytime Contact Phone number

***NOTE: The child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability.**

SCHOOL USE ONLY

Copies to:

- Nurse
- Child Nutrition Office