Request for Alternative School Nutrition

Student's Name: ______________________________

DOB: ___________________

School: ____________________________

I certify that the above listed student has the following medical or other special dietary needs that must be accommodated by the food service program:

Medical Condition:
Allergy _________
Unable to Chew________
Nothing by Mouth (tube fed) _______
Diabetes _______
Other ____

Foods to be omitted:
Milk________
Milk Products____
Citrus Products_____
Sugar_____
Peanuts_____
Other____

Please provide comments regarding food preparation; food substitutes or other comments:

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Physician's Signature **Date**