

## Montgomery ISD Child Nutrition Programs Food Allergy/Disability Substitution Request

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade/Classroom: \_\_\_\_\_  
 Identify the student's disability: \_\_\_\_\_

### Food Allergy/Special Nutritional or Feeding Needs

Please indicate your child's 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 LACTOSE/DAIRY FREE: Is your student restricted only from fluid milk?**    YES    NO

Non Allowable Food	may be substituted with	Allowable Food(s)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above named 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

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature of Physician (Required)

\_\_\_\_\_  
Date

I understand that if my child's medical or health needs change, it is my responsibility to notify the school office.

\_\_\_\_\_  
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.**

Copies to:    Nurse                       Child Nutrition Office                       Campus File

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