DIOCESE OF SHREVEPORT
Child Nutrition Program
Healthy Tools to Help at School

3500 Fairfield Avenue
Shreveport, LA 71104
(318) 219-7297
Fax (318) 868-5057

Allergy/Food Restrictions Form

Student's Name_____ Age_____

School_____ Grade/Classroom_____

Parent's Name_____

Address _____Telephone (_____) _____
(Street or P. O. Box)

City_____ State_____

Does the student have a disability that requires a special diet modification? Yes_____ No_____

Diet Prescription (Check all that apply.):

____ Diabetic

____ Food Allergy

____ Hypoglycemic

____ Other_____

Foods Omitted and Substitutions: Please identify specific foods to omit and list foods to be substituted. (i.e. Omit milk and substitute juice)

Specific Foods to Omit	Specific Foods to Substitute
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Office Address_____Office Telephone # (_____) _____

_____ _____

[1]Licensed Physician/Recognized Medical Authority Signature Date