



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 # (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
<sup>1</sup>Licensed Physician/Recognized Medical Authority Signature

\_\_\_\_\_  
 Date

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