



**Annual Physician's Statement for Children
Requiring Menu Modifications or Substitutions during the School Day**

Child's Name:	
Grade:	
School:	
Phone #:	

I consent to the sharing of relevant medical information between the school and the physician's office.

Parent Signature

Print Parent Name

Date

Phone Number

All below sections must be completed by physician.

Child's condition requiring menu modification or substitution:*	
Explanation for the restrictions of the child's diet:	
The food or foods to be omitted from the child's diet:	
And the food or foods that must be substituted and/or modified?	

*In addition, please mark the appropriate box:

Severe Non-Severe Intolerance

Severe – allergy causing anaphylactic shock

Non-severe – allergy not causing anaphylactic shock

Intolerance – an adverse digestive response

Licensed Physician Signature

Print Physician Signature

Date

Phone Number