Arlington Heights School District 25

FORM F

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

Please complete and return ONLY if you are requesting a lunch meal substitution for your child.

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

☐ Check box if you wish Food Service Department to contact you regarding the availability of Safe Meals.

All below sections must be completed by physician.

	Food Allergy	Circle Severity *		
Child's condition requiring menu modification or substitution:*		S	N	I
		S	N	I
		S	N	I
		S	N	I
		S	N	I
Explanation for the restrictions of the child's diet:				
The food or foods to be omitted from the child's diet:				
Food or foods that must be substituted and/or modified:				

*Circle appropriately for each allergy

S = Severe N = Non-Severe I =Intolerance

Severe – allergy causing anaphylactic shock
Non-severe – allergy not causing anaphylactic shock

_____ _____
Licensed Physician Signature Print Physician Signature

_____ _____
Date Phone Number

NOTE – This form MUST be updated yearly