

**CAFETERIA** – COMPLETE ONLY IF YOUR CHILD NEEDS DIET MODIFICATION IN CAFETERIA

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name \_\_\_\_\_  
School Name \_\_\_\_\_

Student Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY  
MUST HAVE THIS SECTION COMPLETED BY A PHYSICIAN**

PHYSICIAN'S STATEMENT Date \_\_\_\_\_

I declare the child listed above to possess a LIFE THREATENING FOOD ALLERGY. \_\_\_\_\_  
**Physician's Name (please PRINT)**

1. Life threatening food allergy – Circle all foods that must be omitted:

milk    peanuts    tree nuts    eggs    fish    shellfish    wheat    soy    gluten    other  
life threatening food allergy, specify \_\_\_\_\_

2. Can the student consume foods where the allergen is an ingredient in the food product? \_\_\_\_ yes \_\_\_\_ no  
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)

Explain:

3. Foods to Substitute (*NOTE: WCS cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or physician refers patient to registered dietitian who specifies menu items.*)

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Clinic/Facility and Address

\_\_\_\_\_  
**Parent's Signature**

\_\_\_\_\_  
Telephone

Additional Notes:

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