Brazos ISD Child Nutrition Programs
Food Allergy/Disability Substitution Request

Student's Name_____ Age: _____

School: _____ Grade/Classroom_____

Identify the Student's disability: _____

Food Allergy/Special Nutritional or Feeding Needs
Please indicate your child's special needs below:
□ Diabetic □ Lactose Free □ Peanut Allergy □ Other: _____

For Use by Physician Only

Non Allowable	may be substituted with	Allowable Food
_____		_____
_____		_____
_____		_____
_____		_____

I certify that the above named student needs to be offered food substitutes as described above because of the student's medical allergy or disability indicated above. (Use back of form if needed.)

_____ _____
Name of Physician Telephone Number

_____ _____
Signature of Physician **(Required)** Date

I understand that if my child's medical or health needs change, it is my responsibility to notify the school.

_____ _____
Signature of Parent/Guardian Date

Daytime Contact Phone Number_____

***Note: The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability.**

Copies to: □ **Nurse** □**Child Nutrition Office** □ **Campus file (Caft. Manager)**

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