



# Holy Family School

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## Children with Food Allergies Requesting Special Foods

To be filled out by Parent/Guardian:

Name of Student: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

To be filled out by a Medical Authority:

Diagnosis (Include description of the patient's medical or other special dietary needs that restrict the child's diet.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List food(s) to be omitted from diet: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List food(s) that may be substituted (Diet Plan) and any modifications of texture or consistency that are necessary.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Special Equipment:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Medical Authority

\_\_\_\_\_  
Telephone Number