**Lebanon R-III School District**
**Medical Statement for Students Requiring Special Meals**

| **Name of Student:** | **School Attending:** |
|---|---|
| **Date of Birth :** | **Phone #:** |
| **Parent/Guardian Name :** | |

If special meals are needed and requested, certification from a medical doctor must (1) verify that special meals are needed because of a diagnosis , and (2) prescribe the alternate foods and forms needed._____
_____

2. Why /How does handicap/diagnosis restrict the student's diet?_____

**Food Intolerance**:_____

**Food Allergy**:_____
Type of reaction to food: i.e., hives, GI distress, possible anaphylaxis, other- please identify:
_____

Is the food allergy life-threatening (anaphylaxis)? __yes __no
Which specific food(s) cause anaphylaxis?_____

| **Food(s) to be omitted from Student's Diet:** | **YES** | **Food(s) to be substituted:** |
|---|---|---|
| Milk: liquid | | |
| Milk: whey or casein protein allergy | | |
| Is milk baked into foods OK? | | |
| Dairy Products: yogurt, cheese, other – please specify: | | |
| Eggs: Soft Scrambled, fresh cooked, raw – please specify: | | |
| Are eggs baked into foods OK? | | |
| Meat/meat alternates – please specify: | | |
| Grains, grain products, gluten – please specify: | | |
| If gluten: is this an intolerance or due to Celiac Disease? | | |
| Fruits, vegetables, please specify: | | |
| Peanuts, tree nuts, all nuts, please specify: | | |
| Other Dietary Information/Instructions: | | |

_____ _____
**Physician's Signature** **Date**

_____
Address City State Zip Phone Fax
Will your child consume school meals? Daily_____ Sometimes_____Rarely_____Never_____

PARENT SIGNATURE: _____ DATE: _____
***Above signature by parent/guardian to also serve as authorization to discuss diagnosis/health with authorizing physician.**