St. Cloud Area School District 742

Reset Form

Special Diet Statement (Food Allergies)

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner.
Submit this completed special diet statement to your child's school nurse. This form must be renewed annually.

Student Information

Student's Full Name: Today's Date:

Name of School Attending: Date of Birth:

Parent/Guardian Name:

Home Phone Number: Work Phone Number:

Required Information: Dietary Accommodation

1. State the student's disability:
2. State the allergen or food to be avoided:
3. Brief explanation of how exposure to this food affects the student:

4. List specific foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

5. Is student able to consume allergen in cooked items? Yes ☐ No ☐

Signatures

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document.

Prescribing Authority Credentials (print): Date:

Signature: Clinic/Hospital:

Phone Number: Fax Number:

This is a request for dietary accommodations and the final determination for accommodations will be made by Health Services and Nutritional Services.

Parent Signature: Date:

This institution is an equal opportunity provider