



PHYSICIAN'S DIET MODIFICATIONS

ALL QUESTIONS MUST BE ANSWERED in order for ANY diet modification or substitution to be made.

Parent/Guardian Name _____ Student Name _____

Campus Name _____ Date of Birth _____

As parent or guardian, I give permission for Aramark, LLC, to contact the Physician's office regarding my child's dietary needs. _____ (Signature)

PART A-STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY COMPLETE THIS PART

(If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART B on the next page.)

PHYSICIAN'S STATEMENT

Date _____

(physician) declare the child listed at top of page to possess the following **DISABILITY**.

1. Life threatening food allergy - Omit these foods:
 fluid milk peanuts tree nuts eggs fish shellfish wheat soy gluten
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. Other life threatening food allergies (list all) - Omit these foods:

4. Explanation of why this disability restricts diet: _____

5. Has your child's food allergy required an EpiPen? _____

6. Major life activity affected by the life threatening food allergy (check all that apply):
(NOTE: Aramark cannot honor this document unless at least one life activity is marked.)

eating caring for one's self performing manual tasks walking seeing
 hearing speaking breathing learning

7. Foods to Substitute (NOTE: Aramark, LLC cannot honor this document unless substitutions are listed below.)

Physician's Signature _____

Date _____

Telephone _____

Clinic/Facility Name & Address _____

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