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
Physician's Name (please PRINT)
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