



## Food Allergy Notification Order Form

*This form is to be completed by a licensed physician (or other medical authority) for students who have been diagnosed with a life threatening food allergy or a disability and requires a special diet or food accommodation. Please note, an individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as well as the USDA's nondiscrimination regulation, as a person who has physical or mental impairment that substantially limits one or more major life activities that all reasonable requests for food and beverage substitutions will be made so the student can eat.*

<b>PART I - Parent/Legal Guardian to complete this section:</b>		Student Grade: _____	Student ID# _____	Sex: M F			
Student Last Name _____		Student First Name _____					
School Building _____	Parent/Legal Guardian Name (s) _____	Phone # _____					
Parent/Legal Guardian Name (s) _____		Phone # _____					
Parent/Legal Guardian Email Address: _____							
Which of the above numbers is the best way to contact with questions? <input type="checkbox"/> Phone <input type="checkbox"/> Email							
<b>***** PART II, III &amp; IV BELOW MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN/MEDICAL AUTHORITY *****</b>							
<b>PART II - To be completed by licensed physician or medical authority any time there is a change in the diagnosis regarding food allergies on this student. Please check all FOODS to be avoided by this student in order to prevent a life-threatening reaction:</b>							
<input type="checkbox"/> Eggs	<input type="checkbox"/> Dairy	<input type="checkbox"/> Soy	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Wheat	<input type="checkbox"/> Fish	<input type="checkbox"/> Seafood
Other Food (s): (Please specify)							
Please list the appropriate foods to substitute for the allergen-containing foods listed above:							
<b>PART III - To be completed by licensed physician or medical authority any time there is a change in the diagnosis regarding a disability for this student.</b>							
Student's Disability:							
Brief Explanation of why the disability restricts the student's diet:							
Please identify the major life activity affected by the disability:							
Physician Signature:			Date Signed:				
Printed Name of Physician:			Doctor's Office Phone #:				

<i>Tippecanoe School Corporation Use Only:</i>	
<b>SIGNATURE OF PERSON ACCEPTING ORDER</b>	<b>ADMINISTRATION</b>
_____	_____

# Food Allergy Notification Plan—Tippecanoe School Corporation

Parent of student with a disability OR life-threatening food allergy that requires a special diet accommodation should follow this flow chart in order to ensure proper communication of your child's needs.

