Columbia Borough School District
Food Service Department
SPECIAL DIETARY RESTRICTION FORM

Date ____________________________

Student's Name ________________________________ School ___________________________

Student's Age ___________________ Grade/Teacher __________________________________

Does the student have any special nutritional or feeding needs? _____ YES _____ NO

Please fill out the following form if the student has any special needs or meal consideration (please be specific) and attach a physicians order:

I hereby authorize that a physician may release medical information to the Columbia Borough School District related to the following items so they may be considered in the cafeteria meal service:

1. Food Allergies ____
2. Food Intolerances ____
3. Any others (please explain) ____
____
____
____
____

Parent Signature _____________________________________ Date ____________________

* Attach the physician's orders and return this form to the school nurse.

If the student has any other nutritional or feeding needs that you wish to discuss, please feel free to call the school nurse, cafeteria manager at the building of attendance or the District Food Service Director.