PLAINFIELD COMMUNITY SCHOOL CORPORATION
FOOD SERVICE DEPARTMENT
MEDICAL STATEMENT & DIET PRESCRIPTION FOR MEALS AT SCHOOLS
(FORM IS TO BE FILLED OUT BY PHYSICIAN)

Student Name:_____ DOB:_____

School:_____ Grade:_____ Teacher:_____

Diagnosis:_____

Diagnosis length: _____short term _____ long term
If short term please specify date prescription ends:_____

Describe the student's food allergy or intolerance:_____

_____

☐ Is It Life Threating

Please list any dietary restrictions or special diet:_____

_____

List food Ingredients to be avoided:

1._____
2._____
3._____
4._____
5._____

If there is a substitution for the avoided item please list below:

1._____
2._____
3._____
4._____
5._____

_____ _____ _____
Signature of the M.D. or Authorized Medical Authority **Date** **Telephone #**

_____
Address of the Medical Office

_____ _____ _____
Parent's Signature **Date** **Telephone #**