Attala County School District Child Nutrition Department

Individualized Health Plan

Date: _____ Student's Name: _____

School: _____ Grade/Classroom:_____

Identify the student's disability : _____

Food Allergy/Special Nutritional or Feeding Needs Please indicate your child's special needs below:

□ **Diabetic*** □ Lactose Free □ Peanut Allergy □ Other: _____

***FOR DIABETIC ONLY: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.**

FOR USE BY PHYSICIAN ONLY

Non-Allowable Food	may be substituted with	Allowable Food(s)*
_____		_____
_____		_____
_____		_____
_____		_____

I certify that the above-named student needs to be offered food substitutes as described above because of the student's medical allergy or disability indicated above.

_____ _____

Name of Physician Telephone Number

_____ _____

Signature of Physician **(Required)** Date

I understand that if my child's medical or health need change, it is my responsibility to notify the school office.

_____ _____

Signature of Parent/Guardian Date

Daytime Contact Phone Number _____

***NOTE: The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability. Copies to: ☐ Nurse ☐ Child Nutrition Office ☐ Campus File**