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I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Name of Medical Authority: _____ ☐ MD ☐ DO ☐ RD ☐ PA ☐ NP ☐ SLP
(PLEASE PRINT)

Prescribing Physician/Medical Authority Signature: _____
(SIGNATURE) (DATE)