☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐

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)