



FOOD ALLERGY CERTIFICATION

Child's Name _____

Physician Statement: The child listed above is under my care and is allergic to following milk products.

I recommend the following substitutions:

- () All Fluid Milk replace with _____
- () Cow/Goat Milk replace with _____
- () Iron Fortified Infant Formula replace with _____
- () _____ replace with _____

USDA recommends substituting Milk with Full Strength Fruit Juice or Lactose Free Milk

Physician's Signature

____/____/_____
Date

Additional Comments:

Verification of Other Food Allergies:

Does not require a doctor's signature. Food item will be replaced by another item in the same food group.

Food Item	Allergy Level (circle one)		
	S	M	T
_____	S	M	T
_____	S	M	T
_____	S	M	T
_____	S	M	T
_____	S	M	T
_____	S	M	T

Levels: S = Severely Allergic M = Moderately Allergic T = Temporarily Allergic

Parent's Signature

____/____/_____
Date