Heritage Christian School

2107 6th Street SW, Canton, Ohio 44706 | HeritageChristianSchool.org
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Meal Substitution Request Form

Child's Name	
DOB	
Meal Concern Classification	☐ Allergy ☐ Intolerance

Please describe the child's allergy or intolerance. List specific foods and be as specific as possible as to which foods need substituted:

_____
_____
_____
_____

For milk allergies/intolerances, the following should be substituted for milk during meals:

	Almond Milk
	Other (specify)

*If the child has a substitution related to an intolerance or life threatening allergy, a Medical Statement from a licensed physician is required and a substitution will be provided by our food service department. Meal substitutions can only be made for two weeks while waiting for a physician signature.

Parent/ Guardian Signature_____Date: _____

Physician Signature_____ Date: _____

Physician Office Phone Number: _____

OFFICE USE ONLY

- ☐ Copy in Student File
- ☐ Copy to Nurse
- ☐ Copy to Cafeteria