Burris Laboratory School

Statement for Students with Dietary Restrictions

Burris Cafeteria can provide dietary accommodations for any student with a medically documented condition. Please complete this form completely.

Student:_____DOB_____

Grade_____Age:_____ Classroom:_____

Parent/Guardian:_____

Phone: (day)_____(evening)_____

Email:_____

How may we contact you? Circle: Phone / Email

To be completed by physician: Check all that apply

____ Dairy Allergy	**____ Peanut Allergy**	**___ Crohn's Disease**
____ Lactose Intolerant	**____ Tree Nut Allergy**	**____ Irritable Bowel Syn.**
____ Wheat allergy	**____ Fish Allergy**	**____ Ulcerative Colitis**
____ Gluten Intolerance	**____ Shellfish allergy**	**____ Short Bowel Synd.**
____ Celiac Disease	**____ Corn Allergy**	**____ Oral Surgery**
____ Egg Allergy	**____ Diabetes**	**____ Other, _____**
____ Soy Allergy	**____ Diverticular Dis.**	**_____**

What are the student's possible reactions to the above indicated allergies or conditions?_____

_____

What are the medically necessary accommodations to help manage the health of the student?_____

Does student have epi-pen/Auvi-Q: ____ Yes ____ No

Indicate the length of time a special diet will be required:

____ Ongoing ____ Temporary from _____ to _____

Physician Printed Name:_____

Physician Signature:_____

Date:_____ Phone:_____

Burris Laboratory Health Clinic Phone: 285-2340 Fax: 285-8620
Dining Services Amanda Kruse Fax: 285-3713