Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Nutrition employee receiving request\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK APPROPRIATE BOX

 ADD ALERT

 DELETE ALERT

 SPECIAL INSTRUCTION



PLEASE NOTE: 1. We will honor request for 48 hours without signature of parent or guardian. If we have

 Not received signature within timeframe, we will no long be able to honor request.

 2. Please provide a doctor note regarding food allergy.

Return form along with Doctor’s note to cafeteria manager at your child’s school