MEDICAL REFERRAL

Christian Academy School System - This form is to be completed and maintained for each student with food allergies and kept with the student's records at the school cafeteria (even if your student is not planning to make any purchases in the school cafeteria).

TO BE COMPLETED BY PARENT/GUARDIAN

Date___________________________

Student____

Lunch PIN_____________________

Teacher____

Parent/Guardian__________________________________

Phone__________________________

Address_______________________________Zip__________

Please Circle Allergy: Peanuts Tree Nuts Dairy Egg Soy Seafood Shellfish Wheat

Other____

What additional allergy assistance/consideration does your child require?

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Note to Parent/Guardian: Please sign below and return this form to the school Cafeteria Manager. Your prompt attention and assistance is appreciated. Signature

_____________________________Date_________________