



COAST Charter School

48 Shell Island Rd, St. Marks, Florida 32355

Telephone (850) 925-6344

Current School Year: _____

COAST Charter School Diet Modification Request Form

This form must be signed by a physician.

Physician's Name: _____ Phone Number: _____

Student's Name: _____

State medical condition that restricts diet:

State specific foods to be omitted from diet:

Can the food item(s) be consumed in cooked or processed foods? Yes _____ No _____

List specific foods to be used as a substitution: (Federal guidelines allow only lactose-free milk or soy milk to be substituted for lactose intolerance.)

Describe the allergic reaction:

Certification Statement:

I certify that the above diet modification is due to a medical condition that is:

Life Threatening _____ Non-life threatening _____

Physician's Signature: _____

For diet modification to be considered, I authorize the release of medical information specific to this condition to school administrators, health aides, and food service personnel.

Parent Signature: _____ Date: _____

This form is required for the school to accommodate dietary modifications and must be on file in the school cafeteria. Accommodations for dietary modifications will be determined case by case.