# Hooks ISD

## Dietary Restriction Form

Campus:_____

Student Name:_____Grade:_____

Physician's Statement

The above named student possesses the following food allergy and/or special diet. Alternate food should be offered in accordance with the following guidelines.

Food Allergy_____

_____

Special Diet_____

Alternate Feeding Guidelines_____

Physician's Signature_____

Physician's Name_____

Clinic Name_____

Telephone number_____