Food Allergy & Special Dietary Need Information

If your child has a food allergy or requires dietary needs please have a licensed physician complete a **Medical Statement** and return it by mail, fax, or email to:

East Tallahatchie School District

Office of Child Nutrition – Shannon Paige

411 East Chestnut Street

Charleston, MS 38921

662-647-5524 Ext. 106

662-647-3720 (Fax)

spaige@etsdk12.org

If you cannot eat certain food(s) due to religious purposes, Please have a pastor or Minister complete the Religious Statement and return it by mail, Fax, or email to:

East Tallahatchie School District

Office of Child Nutrition – Shannon Paige

411 East Chestnut Street

Charleston, MS 38921

662-647-5524 Ext. 106

662-647-3720 (Fax)

spaige@etsdk12.org

Exhibit 6.4. Religious Statement for a Child or Children

Mississippi Department of Education
Office of Child Nutrition
Religious Statement for a Child/Children

Part I (to be completed by School District/School/Organization/Sponsor)
Date____________________________

Name of School District/School/Organization/Sponsor____

Name of Student/Individual____

Address____

____Date of Birth_____________________

School/Provider/Center Name____

School/Provider/Center Address____

Part II (to be completed by a Minister or other Head Authority in Religious Denomination)

Name of Student/Individual____Age___________

Quote or list the Religious Belief or Church Law or Canon that restricts the student's/individual's diet

____

____

____

____

List the food(s) that should be omitted from the child's diet and food(s) that may be substituted based on the answer given above____

____

____

____

______________________ ____
Date Signature of Religious Authority

Exhibit 6.1. Medical Statement for Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Disabled Child

Part I (to be completed by School District/School/Organization/Sponsor)
Date________________________

Name of School District/School/Organization/Sponsor____

Name of Student/Disabled Person____

Address____

____Date of Birth________________________

School/Provider/Center Name____

School/Provider/Center Address____

Part II (to be completed by the Physician)

Patient's Name____Age________________

Diagnosis____

____

Describe the individual's disability and the major life activity affected by the disability_______________

____

____

Does the disability restrict the individual's diet? Yes______ No______

If yes, list food(s) to be omitted from diet and food(s) that may be substituted____________________

____

____

Special equipment needed____

____

____

______________________ ____
Date Signature of Physician