Jefferson County Christian School
ROYALS

125 Fernwood Road, Wintersville, OH 43953
Phone: 740-275-4326 Fax-740-275-4296
www.myjccs.org

Meal Substitution Request Form

Child's Name	
Date of Birth	
Meal Concern Classification	☐ Allergy ☐ Intolerance

Please describe the child's allergy or intolerance. List specific foods and be as specific as possible as to which foods need substituted:

_____

_____

_____

_____

For milk allergies/intolerances, the following should be substituted for milk during meals:

☐ Almond Milk

☐ Other (specify)

*If the child has a substitution related to an intolerance or life-threatening allergy, a Medical Statement from a licensed physician is required and a substitution will be provided by our food service department. Meal substitutions can only be made for two weeks while waiting for a physician signature.

Parent/ Guardian Signature_____Date: _____

Physician Signature_____ Date: _____

Physician Office Phone Number: _____

OFFICE USE ONLY

☐ Copy in Student File

☐ Copy to Nurse

☐ Copy to Cafeteria

These things I command you, that ye love one another. John 15:17