NORTH SYRACUSE CENTRAL SCHOOL DISTRICT

FOOD ALLERGY CHANGE OF STATUS FORM

_____CAFETERIA

(School Name)

Student Name _____

School _____

Parent's Name _____

Phone No. _____

Address _____

My student is no longer allergic or no longer has a food intolerance to _____

_____

_____

Signature indicates agreement to allow the North Syracuse Central School District to share information on this document with appropriate personnel.

Parent Signature _____Date_____

A physician's note must be submitted to the school nurse, if you are reporting a **change in your child's food allergy or intolerance**.
A physician's note can be faxed or submitted in person to appropriate school.

Physician's Signature_____Date_____

(Please return to cafeteria cashier.)