SEWANHAKA CENTRAL HIGH SCHOOL DISTRICT

APPLICATION for
MEAL SERVICE TO CHILDREN WITH DISABILITIES

Student Name ______________________________ DOB _______ SCHOOL ________________________

Parent Name ____

Home Phone ______________________________________ Work Phone ___________________________

Address ____

Physician's Statement

Date ______________________________

Student Disability ____

Dietary Restrictions ____

Physician's Name ____
(Please print)

Signature ____

Address ____

Phone ____