Birthday Ice Cream Order Form

Parent will complete information below and submit with payment to the school cafeteria ***two weeks before celebration***. The cost is fifty cents (50¢) per treat.

School cafeteria staff will complete their section and submit to school nurse.

School nurse will enter dietary restrictions, make a copy of the form for the teacher, and return the original to the cafeteria.

Treats may be consumed during regular lunch period only

This section to be completed by parent/guardian

Student Name: _____

Teacher/Home Room: _____

Day/Date of Event: _____ # of treats needed:_____

Ice Cream Treat Choice: ___ Fudge Bar (gluten-free) ___ Ice Cream Sandwich

___ Orange Push-Up (gluten-free) ___ Fruit Slush (dairy-free)

___ Chocolate, Vanilla, Strawberry Cup

****School nutrition manager will provide dairy-free item for students with dairy intolerance/allergy as indicated by school nurse below****

This section to be completed by cafeteria personnel

Amount Paid: _____ ____ Cash ____ Check #____

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This section to be completed by school nurse

Students with known dietary restrictions (indicated on student health form)

_____ No known dietary restrictions for this classroom.

_____ Known dietary restrictions listed below.

Student Name	Dietary Restriction
_____	_____
_____	_____

_____ (initial) Nurse Reviewed

_____ (initial) Copy to teacher

_____ **(**initial) Submitted to school nutrition manager with payment on _____ (date)

Revised for PGS on 08/28/17 - vlg