School Year _____--_____

Spring Branch ISD School

Diet Modification Form

PLEASE RETURN FORM TO THE SCHOOL NURSE

Please allow up to 2 weeks for processing. If unable to accommodate, parent will be notified in that time frame. Please complete form in whole.

☐ New Order ☐ Change Order ☐ Discontinue Order ☐ No Changes

Student Information

Student's Name (Last, First):_____ Date of Birth:_____

School: _____ Student ID#: _____ Grade/Teacher: _____

By signing below, I (Parent/Guardian) acknowledge that it is my responsibility to notify any change in my child's dietary needs in writing on this form. I will send completed form to School Nurse and give Child Nutrition Services consent to make modifications to my child's meals and to speak with the healthcare personnel below to discuss the dietary needs on this form. Parent/Guardian

Signature_____ Date:_____

Phone Number: _____ Email: _____

Which meals will the student eat <u>from the school cafeteria?</u> (check all that apply)

☐ Breakfast ☐ Lunch ☐ Snack ☐ None (***if student does not eat from the cafeteria, modifications will not be arranged)***

Medical Information (To Be Completed By A State Licensed Healthcare Professional)

Does the child have a **<u>life-threatening food allergy</u>? (check one)** ☐ **No** ☐ **Yes**

Does the child have a **<u>Disability affecting major life activity requiring diet modification</u>? (check one)** ☐ **No** ☐ **Yes**

Describe the major life activities affected in relation to dietary modification being request: _____

_____

Can the student consume foods where **<u>the allergen is an ingredient</u>**? (Ex: egg in waffles or milk in pancakes)? ☐ **Yes** ☐ **Noce**

Foods to Omit	**Appropriate Substitute(s)**
☐ All Dairy ☐ Fluid Milk ☐ Cheese	☐ Soy Milk ☐ Dairy as an ingredient in baked items
☐ Gluten ☐ Wheat	☐ Gluten Free Diet ☐ Rice, Corn, other grains
☐ Peanuts ☐ Tree Nuts ☐ Soy	☐ Equivalent Protein
☐ Eggs ☐ Shellfish	☐ Chicken ☐ Beef
☐ Corn ☐ Corn Derivatives	☐ Wheat ☐ Rice, only
☐ Texture (Indicate Consistency)_____ ☐ Liquids (indicate Consistency) _____	Other: (please specify)_____ _____
Other (please specify) _____ _____	Food Allergy or Intolerance: ☐ Ingestion ☐ Inhalation ☐ Contact

State Licensed Healthcare Professional Information (Physician, Physician Assistant, Advanced Practice Nurse)

Name of Licensed Healthcare Professional (Print):_____Phone:_____

Signature of Licensed Medical Professional:_____ Date:_____

Name of Clinic/Hospital:_____ Questions? Contact Child Nutrition Services at 713-251-1150