

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.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Which meals will the student eat from the school cafeteria? (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 **life-threatening food allergy?** (check one)     No     Yes

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

**Describe the major life activities affected in relation to dietary modification being request:** \_\_\_\_\_

Can the student consume foods where **the allergen is an ingredient?** (Ex: egg in waffles or milk in pancakes)?     Yes     No

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

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