SCHOOL YEAR _____--_____
PLEASE RETURN FORM TO THE SCHOOL NURSE

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
STUDENT DIET MODIFICATION FORM

Please allow up to 2 weeks for processing. Form needs to be filled out in full or it will be returned.

Student's Name SECTION A: STUDENT INFORMATION – <u>To be completed by Parent/Legal Guardian</u>

(Last, First):_____Date of Birth: ____/____/____

Student ID: _____School: _____Teacher: _____Grade: _____

Parent/Guardian Name: _____ Home Phone: _____

Parent/Guardian Email: _____

I give Nutrition Services/Health Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Nutrition and Food Service dietitian and the school nurse.

Parent/Guardian Signature: _____ Date: _____

SECTION B MEDICAL INFORMATION – TO BE COMPLETED BY A STATE LICENSED HEALTHCARE PROFESSIONAL

<u>Does the child have a **life-threatening** food allergy that requires a diet modification</u>? ☐ NO ☐ YES, complete Section C

Does the child have a prescription for an Epi-pen for a food allergy? ☐ NO ☐ YES

<u>Does the child have a disability affecting major life activity requiring a diet modification?</u> ☐ NO ☐ YES, complete Section D

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, define a person with a disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment."

SECTION C: FOOD ALLERGIES

<u>TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY</u>

FOODS TO OMIT:

____ Wheat/Gluten
____ Peanuts
____ Tree Nuts ____ No foods processed in a facility that contains Nuts
____ Sesame Seeds ____ Sunflower Seeds
Other Seeds (specify) _____
____ Soy
____ Soy Lecithin ___ Soybean Oil
____ Fluid Milk Only ____ Whey Protein ____ Casein Protein
____ All dairy including milk in baked goods ____ Yogurt ___ Cheese
____ Eggs (Whole plain eggs ex: scrambled eggs)
____ All Foods containing egg (ex. Baked goods)
____ No foods processed in a facility that contains eggs
____ Shellfish ____ Fish (please specify below)
_____
____ Corn
____ Cornstarch
____ Corn Syrup
____ Corn Oil
____ Corn Flour

Other (please be specific):_____
_____
_____

SECTION D: DISABILITIES

<u>TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY</u>

Disability: _____
Explanation:_____
_____
_____

Major Life Activities affected by the Disability (REQUIRED)
(Check all that apply)

____ Major Bodily Function ___ Eating ___ Breathing
___ Performing manual tasks ___ Caring for one's self
___ Speaking ___ Walking ___ Hearing ___ Seeing
Other: _____
Foods to Omit:
_____
_____

<u>Texture Modification Needed</u>: ___ Yes ___ No
Liquids: ___ Thin ___ Nectar Thick ___ Honey Thick ___ Pudding Thick
Solids: ___ Pureed ___ Mechanical Soft (chopped)
___ Mechanical Soft (ground)
<u>Therapeutic Diet Order:</u> Please provide specifics as needed
_____
_____

I certify that the above named students' needs to be offered food substitution as described above because of the student's disability and/or life threatening food allergy

Printed Name of Licensed Physician/Prescribing Medical Authority: _____ Date: _____
Signature of Physician/Prescribing Medical Authority: _____ MD DO PA NP SLP
Clinic/Facility Name: _____ Telephone: _____