



# 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 – To be completed by Parent/Legal Guardian

(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

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

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

Does the child have a **disability** affecting major life activity requiring a diet modification?  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

TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY

#### 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

TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY

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:

\_\_\_\_\_

Texture Modification Needed: \_\_\_ Yes \_\_\_ No

Liquids: \_\_\_ Thin \_\_\_ Nectar Thick \_\_\_ Honey Thick \_\_\_ Pudding Thick

Solids: \_\_\_ Pureed \_\_\_ Mechanical Soft (chopped)

\_\_\_ Mechanical Soft (ground)

Therapeutic Diet Order: 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: \_\_\_\_\_

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