Physician's Request for Special Dietary Accommodations

Cleveland Independent School District – Child Nutrition 326 FM 1010 • Cleveland, Texas 77327

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

☐ New Order ☐ Change Order ☐ Discontinue Order ☐ No Changes Date:_____

Student Diet Modification Form (for cafeteria meals ONLY)

Student Last Name:_____First Name:_____MI:_____ Date of Birth:___/___/_____

Student ID#: _____School:_____ Grade:_____

Parent/Guardian Contact Information

Name (print):_____Phone Number: _____Email:_____

I give Child Nutrition & 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 Cleveland ISD.

_____ _____

Parent/Guardian Signature Date

Which meals will the student eat from the school cafeteria? (Check all that apply)

☐ Breakfast ☐ Lunch ☐ None (student will not eat school-provided meals, modifications do not need to be arranged)

The following must be completed by a licensed physician or prescribing medical authority:

Student has a life-threatening/anaphylactic food allergy? ☐ Yes ☐ No

If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded.

Disability: _____ **Major life activity affected by the disability (check all that apply):**

☐ Major Bodily Function ☐ Breathing ☐ Seeing ☐ Speaking ☐ Learning ☐ Eating ☐ Hearing

☐ Walking ☐ Caring for One's Self ☐ Performing Manual Tasks ☐ Other:_____

Texture modification needed?: Soft (chopped) Soft (ground) Pureed Other: _____

Food Allergy (check all foods to be omitted from diet):

☐ Peanuts ☐ Tree Nuts ☐ Fish ☐ Shellfish ☐ Wheat

Dairy Allergy (specify): ☐ Fluid Milk Only ☐ Lactose Free (yogurt, cheese, fluid milk) ☐ All Dairy Including in Baked Goods

Egg Allergy (specify): ☐ Whole Plain Eggs (ex. Scrambled eggs) ☐ All Eggs Including in Baked Goods

Soy Allergy (specify): ☐ No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk) ☐ No Soy as a minor ingredient

Other (please be specific)_____

List Safe Food Substitutes:_____

☐ NO substitutes (delete item from meal with NO substitutes) (Lactose free milk is the standard substitution when fluid dairy milk is omitted)

Substitutes must be listed for items omitted above

If a student must omit MILK or EGGS AS AN INGREDIENT, SOY, WHEAT, or HAS MULTIPLE FOOD ALLERGIES, we must provide them with an Allergen-Free Meal with very limited options

I certify that the above-named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy as indicated.

Name of Licensed Physician/Medical Authority (print): _____ Date:_____

Physician/ Prescribing Medical Authority Signature: _____

Clinic Name & Address: _____

Clinic Phone:_____

Please allow up to 6 weeks for processing. Questions? Contact Child Nutrition Services at 281-592-2618