



Splendor Independent School District

23419 FM 2090, Splendor, Texas 77372
281-689-3128 • Fax 281-689-7509

PARENT/GUARDIAN: **RETURN FORM TO SCHOOL NURSE**

Parent/Guardian Name: _____

Student Name: _____

Campus Name: _____ Student Grade: _____

Physician's Diet Modifications

Please complete this page for DISABILITIES/IMPAIRMENTS REQUIRING PHYSICIAN'S DIET MODIFICATION. The U.S. Department of Agriculture School Meals Program requires that all questions be answered in order for dietary substitutions and/or modifications to be made.

PHYSICIAN'S STATEMENT

I _____, Physician's Name (please PRINT)

Physician for _____ Child's Name (please PRINT)

declare the herein mentioned child to possess the following severe/life-threatening food allergies and/or special dietary needs related to a disability.

Disability/Impairment requiring meal modification: _____

If food allergy, is it LIFE-THREATENING? _____yes _____no

Reason for diet restriction: _____

Foods to Omit: _____

Foods to Substitute: _____

Physician Signature: _____ Date: _____

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____

This institution is an equal opportunity provider.

Right People • Right Things • Right Way • Right Resources • Right Relationships