



Special Diet Statement

Please complete for School Meals and Classroom Information Purposes.
Return to your student's campus or email to foodservice@pearlandisd.org
or Fax to 281-412-1435

PART 1: STUDENT INFORMATION – PARENT OR GUARDIAN MUST COMPLETE. PLEASE PRINT

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone Number: _____

Meals to be purchased at school: Breakfast Lunch This student will bring all meals and snacks from home.

As parent or guardian, I give permission for Pearland ISD School Nurse and Food Service Dietitian to contact the Physician's Office regarding my child's dietary needs: _____ (Signature)

PART 2: Medical Documentation of the Need for Special Diet Modification

LICENSED PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT MUST COMPLETE. PLEASE PRINT.

Food Allergy: Please check the box for the specific food allergy the student has

- Peanuts and Peanut Butter** **Tree Nuts** **Fish** **Shellfish**
- Eggs: Whole Eggs Only** **Eggs: Both as Whole Eggs and when used as an Ingredient**
- Milk: Fluid, Fresh Milk Only** **Milk: Both as Fluid, Fresh and as an Ingredient**
- Wheat** **OTHER** _____

Lactose Intolerant: No Regular Cow's milk to drink, but Lactose Free Milk and Cheese is allowed.

Lactose Intolerant: No Regular Cow's milk and No cheese. Lactose Free Milk allowed.

Additional information related to the student's need for a modified diet or substitutions:

Licensed Provider Name / Credentials (print): _____

(Physician, Nurse Practitioner, or Physician's Assistant)

Signature: _____ **Date:** _____

Clinic Name: _____

Phone: _____ **Fax:** _____

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OFFICE: Student ID# _____ Campus _____ Grade _____