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:** _____

OFFICE: *Student ID#* _____ *Campus* _____ *Grade* _____