Physician's Statement
Barbers Hill ISD School Nutrition Department

☐ NEW MEAL MODIFICATION ☐ CHANGE CURRENT MEAL MODIFICATION ☐ DISCONTINUE MEAL MODIFICATION

Note: Accommodations will only be made if there is a documented life-threatening food allergy or disability and will not be made until all documentation has been returned and approved.

This form does not need to be renewed every year. Fill out a new form only if dietary needs have changed.

A. STUDENT INFORMATION (THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN)

Student Name: _____ Date of Birth: _____

Student ID: _____ Campus: _____

Parent/Guardian: _____ Phone Number: _____

Email: _____ Date: _____

B. SCHOOL NUTRITION CAFETERIA FOODS (THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN)

Will student be eating breakfast and/or lunch at school?

☐ **YES** – Student will be eating breakfast and/or lunch at school. If yes, please complete Section D and E.

Please select all that apply: ☐ Breakfast ☐ Lunch

☐ **NO** – Student will not be eating breakfast and lunch at school. All food eaten by student will be supplied by parent/legal guardian.

C. THIS SECTION TO BE COMPLETED BY STATE LICENCED HEALTHCARE PROFESSIONAL AUTHORIZED TO WRITE PRESCRIPTIONS (Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a person with a "disability is any person who has a physical or mental impairment that substantially limits one or more life activity," including food anaphylaxis.)

Need for Diet Modification:

- Does this child have a **food** allergy or intolerance? ☐ **No** ☐ **Yes** (If Yes, complete Section D.)
- Could consumption of the food to which the child is allergic/intolerant result in a life threatening (anaphylactic) reaction? ☐ **No** ☐ **Yes**

  If yes, describe the nature of the reaction. Please be specific. _____

  _____
- Whether or not the child has a food allergy/intolerance, does the child have a medical condition requiring diet modification? ☐ **No** ☐ **Yes** (If yes, complete Section D.)

D. LIFE THREATENING FOOD ALLERGY AND/OR OTHER MEDICAL CONDITION (Please note: Barbers Hill cannot honor this document unless all fields are completed.)

Student's medical condition/disability: _____

Explain why the disability restricts the student's diet: _____

Major life activity affected by the disability: _____

If the allergy is not life-threatening, what is the nature of the child's medical condition requiring diet modification?

_____

Is this a temporary or permanent condition? ☐ Temporary ☐ Permanent

If temporary, how long is it expected to last? _____

Why does the medical condition require a diet modification? _____

Check all applicable food allergies (omit these foods):

☐ Corn ☐ Egg ☐ Fish ☐ Milk ☐ Peanuts
☐ Shellfish ☐ Soy ☐ Tree Nuts ☐ Wheat ☐ Sesame

Milk Allergy (specify):
☐ Fluid Milk
☐ Milk Products (yogurt, cheese, etc.)
☐ All Milk (including as an ingredient in baked goods)

Egg Allergy (specify):
☐ Whole Egg (scrambled eggs, etc.)
☐ Egg as an ingredient (pancakes, muffins, etc.)

Soy Allergy (specify):
☐ Soy as main ingredient (soy milk, edamame, soy sauce, etc.)
☐ Soy as minor ingredient (soy in processed foods, soy oil, soy lecithin, etc.)

Corn Allergy (specify):
☐ Corn as main ingredient (corn kernels, corn tortilla, etc.)
☐ Corn as minor ingredient (corn oil, corn syrup, etc.)

Other (be specific): _____

Suggested types of foods to be substituted (If none, please write "none".) _____

Is texture modification required? ☐ No ☐ Yes (If Yes, complete Section E.)

E. TEXTURE MODIFICATION, IF APPLICABLE

☐ Puree ☐ Chopped, specify size (1/4" bite sized pieces): _____
☐ Soft ☐ Other: _____

F. PHYSICIAN INFORMATION

Physician Name: _____ Phone Number: _____
Clinic/Facility Name: _____ Fax Number: _____
Address: _____ City, State, Zip: _____
Physician Signature: _____ Date: _____

G. RETURN COMPLETED FORM TO BARBERS HILL SCHOOL NUTRITION DEPARTMENT

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