

**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):**

- |                                    |                              |                                    |                                |                                  |
|------------------------------------|------------------------------|------------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Corn      | <input type="checkbox"/> Egg | <input type="checkbox"/> Fish      | <input type="checkbox"/> Milk  | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Soy | <input type="checkbox"/> Tree Nuts | <input type="checkbox"/> Wheat | <input type="checkbox"/> 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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