

College Station Independent School District - Child Nutrition

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PLEASE RETURN FORM TO THE CHILD NUTRITION OFFICE

Student Diet Modification Form (for cafeteria meals ONLY)

Revised 6/19

Student Last Name: _____ First Name: _____

Date of Birth: ____/____/____ School: _____

Parent/Guardian Contact Information

Name (print): _____ Phone Number: _____ Email: _____

I give Child Nutrition & Health Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to College Station ISD.

Parent/Guardian Signature _____ Date: _____

Which meals will the student eat from the school cafeteria? (check all that apply)

Breakfast Lunch None

(Modifications will only be made if a meal session box is selected. Only full meals are modified. A la carte and snack purchases should be monitored by student and guardians).

Student has a life-threatening/anaphylactic food allergy? Yes (complete section A) No (complete section B)

If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded.

The following must be completed by a licensed physician or prescribing medical authority:

Section A: Food Allergy (check all foods to be omitted from diet):

Peanuts Tree Nuts Fish Shellfish Wheat

Dairy Allergy (specify): Fluid Milk Only
 All Dairy Including in Baked Goods

Egg Allergy (specify): Whole Plain Eggs (ex. Scrambled eggs)
 No Eggs Including in Baked Goods

Soy Allergy (specify):
 No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk)
 No Soy as a minor ingredient (ex. Soy filler in meats, soybean oil)

Corn Allergy (specify):
 No Corn as a main ingredient (ex. corn kernels, corn on the cobb)
 No Corn as a minor ingredient (ex. corn oil, corn syrup)

Other (please be specific) _____

Safe Food Substitutes: _____

Section B: Disability

Disability: _____

Major life activity affected by the disability (check all that apply):

Breathing Seeing Speaking
 Learning Eating Hearing
 Walking Caring for One's Self
 Performing Manual Tasks
 Other: _____

Texture modification needed?:

Solids: No Solids Pureed Chopped
 Mechanical Soft Regular

Liquids: No Liquids Thin Thickened
 Nectar Honey Pudding

Other: _____

Name of Licensed Physician (print): _____ Physician's Signature: _____

Clinic Name & Address: _____ Date: _____ Phone: _____

Please allow up to 2 weeks for processing.

Questions? Contact Child Nutrition Services at 979-764-5450

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