

New Caney ISD Physician Diet Modification



New Form
 Revised Form
 Discontinue Allergy request / Restriction

Section A - To be completed by Parent/Legal Guardian

Student ID# _____
 Student's Name (Last, First) _____ Date of Birth _____
 School _____ Grade _____
 Parent / Guardian _____ Home Phone _____
 Parent / Guardian Email _____

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 the Child Nutrition and Food Service Department and as well as School Nurse.

Parent / Guardian Signature _____ Date _____

FOOD ALLERGY and / or DISABILITY information to be Completed by a LICENSED PHYSICIAN or PRESCRIBING MEDICAL AUTHORITY

Does the Student have a life threatening food allergy? Yes No
 Does the student have an identified disability (IEP or 504)? Yes No

- Peanuts
- Tree Nuts
- Milk Allergy Fluid Milk ONLY
- All Dairy including in baked goods (ex. Breading, muffins, rolls)
- Egg Allergy Whole Plain Eggs(ex.Scrambled Eggs)
- Eggs in baked goods (ex. rolls muffins)
- Soy Allergy
- Soy, **main** (ex. Edamame, soy sauce, soy milk)
- Soy, **minor** (ex. Soy filler in meats, soybean oil)
- Fish Crustacean / Shellfish
- Wheat Sesame Seeds
- Other (please be specific): _____

Disability: _____

Major Life Activity affected by the Disability (REQUIRED)

- Major Bodily Function Eating Breathing
- Performing manual tasks Self-care
- Speaking Learning Walking
- Hearing Seeing
- Other: _____

Texture Modifications Needed? Yes No

Liquids:

- Thin/Regular Slightly Thick (Level 1)
- Mildly Thick (Level 2) Other: _____

Solids:

- Pureed (Level 4) Minced/Moist (Level 5)
- Soft & Bite - Sized (Level 6)

Supplement Needed? Yes No

Supplement: (ex. Ensure, Boost) _____

Foods to substitute _____

Substitutions: Based on availability. NCISD Child Nutrition Dept. will make every effort to honor substitution request.

STATE LICENSED HEALTHCARE PROFESSIONAL INFORMATION

Healthcare Professional Notes: _____

Printed Name of Licensed Physician/Prescribing Medical Authority _____ Date: _____

Signature of Physician/Prescribing Medical Authority _____ Phone: _____

Name of Clinic/Hospital: _____ Questions? Contact Child Nutrition Services 281-577 8690

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