

# DIET MODIFICATION FORM

**PLEASE RETURN COMPLETED FORM TO BISD HEALTH SERVICES AT [healthservices@BISD.net](mailto:healthservices@BISD.net) OR fax 254-215-2097**

**Student Name:** \_\_\_\_\_

**Student ID:** \_\_\_\_\_

**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 Belton ISD.*

\_\_\_\_\_  
Parent/Guardian Signature

**Date:** \_\_\_\_\_

**\*\*The following must be completed by a licensed physician or prescribing medical authority.\*\***

### Section A: Lactose Intolerance

- ☐ Lactose Intolerant (**NOT dairy allergy**)
- ☐ No Cheese, No Yogurt
- ☐ No Fluid Milk (Choose substitute below):
- ☐ Lactose Free Milk ☐ Soy Milk ☐ None

### Section B: Food Allergy (check life-threatening foods to omit)

- ☐ Peanuts ☐ Tree Nuts ☐ Fish ☐ Shellfish ☐ Wheat ☐ Sesame
- ☐ **Dairy Allergy** (exclude all products containing dairy, even baked goods)  
Select milk substitute: ☐ Soy Milk ☐ None
- ☐ **Egg Allergy** (specify):
- ☐ Whole Plain Eggs (Scrambled eggs)
- ☐ No Eggs Including in Baked Goods, Ranch Dressing
- ☐ **Soy Allergy** (NOTE: will NOT exclude soybean oil unless requested)

**Other Allergy/Additional Information:** \_\_\_\_\_

**Allowable Food Substitutions:** \_\_\_\_\_

### Section C: Medical

**Does the child have an identified disability and/or life-threatening food allergy?**

☐ Yes ☐ No

Major life activity affected by the disability or food allergy, if applicable (check all that apply):

- ☐ Breathing ☐ Seeing
- ☐ Speaking ☐ Eating
- ☐ Learning ☐ Hearing
- ☐ Walking
- ☐ Caring for One's Self
- ☐ Performing Manual Tasks

☐ Other: \_\_\_\_\_

**Please allow up to 2 weeks for processing.**

Questions? Contact BISD School Nutrition Services at 254-215-2186

**Name of Licensed Physician (print):** \_\_\_\_\_ **Physician's Signature:** \_\_\_\_\_

**Clinic Name & Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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