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 DISABLILITY 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):**_____

_____

Foods to substitute_____

_____

_____

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

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) _____

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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