



Student Meal Accommodation Form

☐ New Order
 ☐ Change Order
 ☐ Discontinue Order
 ☐ No Changes

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Student Last Name: _____ First Name: _____ MI: _____ Date of Birth: ____/____/____

Student ID#: _____ School: _____

Parent/Guardian Contact Information

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

I give Food & Nutrition 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 Manor ISD.

Parent/Guardian Signature _____

Date: _____

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

☐ Breakfast
 ☐ Lunch
 ☐ Supper
 ☐ None (if student does not eat from the cafeteria, modifications will not be arranged)

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):

Dairy Allergy (specify): ☐ Fluid Milk Only ☐ Cheese ☐ Yogurt
☐ All Dairy including in baked goods

Egg Allergy (specify): ☐ Whole Eggs (ex. Scrambled eggs)
☐ Eggs as an ingredient (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 lecithin, soybean oil)

☐ Peanuts
 ☐ Tree Nuts
 ☐ Fish
 ☐ Shellfish
 ☐ Wheat

☐ Sesame

Other (please be specific): _____

Safe Food Substitutes: _____

Section B: Disability

Disability:

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

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

Texture modification needed?:

☐ Regular
 ☐ Soft (ground)
☐ Pureed
 ☐ Soft (chopped)

Other: _____

****If student must omit MILK or EGGS AS AN INGREDIENT, SOY AS A MINOR INGREDIENT, WHEAT, or HAS MULTIPLE FOOD ALLERGIES, we must provide them with an Allergen Free Meal with very limited options****

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

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

Please allow up to 2 weeks for processing.

Questions? Contact Food & Nutrition at 512-278-4080

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