

Waller Independent School District

Student Diet Modification/Allergy Form

Student Last Name: _____ First: _____ Date of Birth: _____

School: _____ Grade: _____ Student ID: _____

Parent/Guardian Contact Information

Name: _____

Phone Number: _____ Email: _____

I give Health Services/School Nutrition Services permission to speak with the Physician to discuss the dietary needs described below.

Date: _____

Parent/Guardian Signature

The following must be completed by a licensed physician:

Does the student have a disability or life threatening food allergy requiring diet modification? *Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a person with “a disability is any person who has a physical or mental impairment that substantially limits one or more life activity” including a life threatening food allergy.*

☐ Yes ☐ No *If the student does NOT have a disability and/or life threatening anaphylactic food allergy, this form does not need to be completed and will be disregarded.

Does the student have a prescription for an Epinephrine Auto-Delivery Device for a food allergy?

☐ Yes ☐ No

Medical Diagnosis: _____

Major life activities affected by the disability: _____

Food to be Omitted:

☐ Peanuts/Tree Nuts ☐ Fish/Shellfish ☐ Wheat*
☐ Fluid Milk ☐ All Dairy Products ☐ All foods containing milk as an ingredient* (Ex. Breaded items dipped in Milk)
☐ Eggs by themselves ☐ All foods containing egg as an ingredient* (Ex. Baked goods)
☐ Soy as a main ingredient (Ex. Soy milk, edamame, soy sauce) ☐ All foods containing soy as a major ingredient* (Ex. Soy in Processed foods)
☐ Other: _____

*If student must omit milk or egg as an ingredient, soy as a minor ingredient, wheat, or has multiple food allergies, we may suggest a meal is brought from home or special modifications will be made to accommodate them to receive meals in the cafeteria.

Accommodations Needed:

☐ Nut free foods
☐ Seafood free foods
☐ No Milk/Dairy
☐ Texture Modified – Only for student with a medical diagnosis of dysphagia
☐ Pureed
☐ Mechanical Soft Chopped
☐ Mechanical Soft Ground
☐ Other: _____

Name of Licensed Physician (Print): _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

PLEASE RETURN TO SCHOOL NURSE

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