



Commerce ISD Diet Modification Form

*This form must be filled out completely BEFORE any dietary modifications or substitutions can be made.
Schools are not required to make modifications to meals based on food preferences.*

Student's ID Number:		Student's Name (Last, First):		Date of Birth:	
☐ New request ☐ Change existing request ☐ Discontinue request		Which meals provided by the school cafeteria will the student eat? ☐ Breakfast ☐ Lunch ☐ None		Does this student have an identified disability? (IEP or 504 Plan) ☐ IEP ☐ 504 ☐ N/A	
Students with a Medical Disability/Life Threatening			Students with NO Medical Disability/Non-Life Threatening		
Section A. To be completed by Physician/Medical Authority			Section B. To be Completed by Physician/Medical Authority		
Does the student have a disability which restricts the student's diet? ☐ Yes ☐ No <i>If yes, describe or state the student's disability or diagnosis. Explain why it restricts the student's diet and list major life activities affected.</i> by _____ the _____ disability: _____ I. Food Allergy Student has allergies that ARE life threatening/anaphylactic: ☐ Yes, continue with this section ☐ No, refer to section B ☐ No Wheat ☐ No Peanut ☐ No Tree Nut ☐ No Sesame ☐ No Fish ☐ No Shellfish ☐ No Soy (<i>soy lecithin & soy oil allowed</i>) ☐ No Milk Egg Allergy ☐ No Whole Eggs (such as scrambled or boiled eggs) ☐ No menu items with egg listed as an ingredient ☐ Other, please list _____ _____ _____ _____ __ Safe Food Substitutions: _____			Food Allergy Student has allergies that are NOT life threatening/anaphylactic: ☐ No Wheat ☐ No Peanut ☐ No Tree Nut ☐ No Sesame ☐ No Fish ☐ No Shellfish ☐ No Soy (<i>soy lecithin & soy oil allowed</i>) ☐ No Milk Egg Allergy ☐ No Whole Eggs (such as scrambled or boiled eggs) ☐ No menu items with egg listed as an ingredient ☐ Other (<i>Please specify if allergen is as a cooked ingredient or when consumed whole/fresh</i>): _____ Safe Food Substitutions: _____		
			Section C. To be completed by a parent or guardian. No medical authority signature required.		
			Lactose Intolerance ☐ No Cheese & Yogurt ☐ No Fluid Milk Substitute with Soy Milk? ☐ Yes ☐ No Religious/Cultural Beliefs: It is against district policy to flag accounts or restrict student options without medical reason. If students are to avoid food items for religious or cultural reasons families are encouraged to review menu items on Commerce ISD website.		
I understand as a parent/guardian, that it is my responsibility to renew this form any time there is a change or discontinuation of dietary needs and give to the _____ school nurse. I give Commerce ISD FNS permission to speak with the medical authority to discuss dietary needs as ordered. ★ Parent/Guardian Signature: _____ Date: _____ Contact number of parent/guardian: _____					
To be completed only by students treating physician, physician assistant or nurse practitioner. <i>I certify that the above-named student needs to be offered food substitutions as described above. FNS will attempt to accommodate substitutions but reserves the right to modify the menu based on product availability.</i>					
Printed Name of Medical Authority: _____ ☐ MD ☐ DO ☐ PA-C ☐ NP					
Email: _____		Phone #: _____		Signature of Medical Authority: _____	
Printed Name of RN: _____ School: _____ Phone #: _____ Date: _____					
Printed Name of School Cafe Manager: _____ Phone #: _____ Date: _____					

*Please send the completed form to your campus nurse for processing. Contact FNS Director at 903-366-0910
carrie.clements@commerceisd.org with any questions or concerns.*

This institution is an equal opportunity provider.

Updated 7/27/26