

Alvin Independent School District

**Student Diet Modification Form**

Student's Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Student ID#: \_\_\_\_\_

**Note: This form does not need to be filled out yearly. Fill out a new form only if food modifications have changed since last form was submitted.**

**I give Child Nutrition Services consent to make modifications to my child's meals. I further authorize Child Nutrition Services and/or School Nurse to speak with the Physician listed below to discuss the dietary needs described on this form.** \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

The U.S. Department of Agriculture School Meals Program requires that **ALL QUESTIONS BE ANSWERED** in order for **ANY** diet modification or substitution to be made in school meals.

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

Breakfast  Lunch  CACFP Supper\*  Summer  None *(if student does not eat from the cafeteria, modifications will not be arranged)*

Does the child have a **life-threatening food allergy?** (check box)  No  Yes **(If yes, Physician completes section A)**

Does the child have a **Disability requiring diet modification?** (check box)  No  Yes **(If yes, Physician completes section B)**

**Sections A and/or B To Be Completed By A Licensed Physician**

**Section A: Life-Threatening Food Allergy**

**Alvin ISD cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below.**

**Life-Threatening Food Allergy** (check all foods to be omitted from diet):

Eggs  Fish  Peanuts  Shellfish  Soy (includes any product containing soy bean derivatives)  Tree nuts  Wheat  
 Milk (casein/whey allergy)  Other: \_\_\_\_\_

Specify: \_\_\_\_\_

Can the student consume foods where the allergen is an **ingredient** in a product (please specify)?  Yes  No  
 (i.e. Can consume eggs in baked goods, but not scrambled eggs)

Explanation: \_\_\_\_\_

**Safe Food Substitutes:** \_\_\_\_\_

Please note that this section is only for those allergens which cause an anaphylactic reaction. This form is not for food sensitivities, mild to moderate food intolerances, testing for allergies through exclusion diets, or life-style choices. Alvin ISD cannot honor this Medical statement unless specific substitutions are listed.

**Section B: Disability**

**Disability:** \_\_\_\_\_

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

Breathing  Seeing  Speaking  Performing manual tasks  Learning  
 Eating  Hearing  Walking  Caring for one's self  Other: \_\_\_\_\_

**Type of Diet:**  Regular  Soft Mechanical  Chopped  Blended  Pureed  Other: \_\_\_\_\_

Name of Licensed Physician (print): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**PLEASE RETURN FORM TO THE CHILD NUTRITION OFFICE** Questions? Contact Child Nutrition Services at 281-245-2277

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