School Year _____--_____ Revised 08/19

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 <u>from the school cafeteria?</u> (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 **<u>life-threatening food allergy</u>? (check box)** ☐ **No** ☐ **Yes** **(If yes, Physician completes section A)**

Does the child have a **<u>Disability requiring diet modification</u>? (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 <u>unless SPECIFIC SUBSTITUTIONS are listed below</u>.

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: _____

<u>Major life activity affected</u> 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