Physician's Request for Special Dietary Accommodations

Brazosport Independent School District – Child Nutrition 202 Lakeview Drive • Clute, Texas 77531

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

☐ New Order ☐ Change Order ☐ Discontinue Order ☐ No Changes Date:_____

Student Diet Modification Form (for cafeteria meals ONLY)

Student Last Name:_____First Name:_____MI:_____ Date of Birth:___/___/_____

Student ID#: _____School:_____ Grade:_____

Parent/Guardian Contact Information

Name (print):_____Phone Number: _____Email:_____

I give Child Nutrition 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 Brazosport ISD.

_____ _____

Parent/Guardian Signature Date

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

☐ Breakfast ☐ Lunch ☐ None (student will not eat school-provided meals, modifications do not need to be arranged)

The following must be completed by a licensed physician or prescribing medical authority:

Student has a life-threatening/anaphylactic food allergy? ☐ Yes ☐ No

If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded.

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?: Soft (chopped) Soft (ground) Pureed Other: _____

Food Allergy (check all foods to be omitted from diet):

☐ Peanuts ☐ Tree Nuts ☐ Fish ☐ Shellfish ☐ Wheat

Dairy Allergy (specify): ☐ Fluid Milk Only ☐ Lactose Free (yogurt, cheese, fluid milk) ☐ All Dairy Including in Baked Goods

Egg Allergy (specify): ☐ Whole Plain Eggs (ex. Scrambled eggs) ☐ All Eggs Including in Baked Goods

Soy Allergy (specify): ☐ No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk) ☐ No Soy as a minor ingredient

Other (please be specific)_____

List Safe Food Substitutes:_____

☐ NO substitutes (delete item from meal with NO substitutes) (Lactose-free milk is the standard substitution when fluid dairy milk is omitted)

Substitutes must be listed for items omitted above

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

I certify that the above-named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy as indicated.

Name of Licensed Physician/Medical Authority (print): _____ Date:_____

Physician/ Prescribing Medical Authority Signature: _____

Clinic Name & Address: _____

Clinic Phone:_____

Please allow up to 6 weeks for processing. Questions? Contact Child Nutrition at 979-730-7110.