



Nederland ISD Child Nutrition Department

## PHYSICIAN'S DIET MODIFICATION

Student Name \_\_\_\_\_ Student ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
School Name \_\_\_\_\_ Parent/Guardian \_\_\_\_\_ Telephone \_\_\_\_\_

*As parent or guardian, I give permission for Nederland ISD to contact the Physician's office regarding my child's dietary needs.* \_\_\_\_\_ (Parent Signature)

**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. This form must be signed by signed a licensed physician.**

### Physician's Statement

#### **LIFE THREATENING FOOD ALLERGY – Omit these foods:**

\_\_\_\_ Fluid Milk (by itself) \_\_\_\_ Milk (as an ingredient) \_\_\_\_ Peanuts \_\_\_\_ Tree nuts \_\_\_\_ Eggs  
\_\_\_\_ Fish \_\_\_\_ Shellfish \_\_\_\_ Wheat \_\_\_\_ Soy \_\_\_\_ Other: \_\_\_\_\_

#### **OTHER DISABLING DIAGNOSES REQUIRING DIETARY MODIFICATION:**

**1. Can the student consume foods where the allergen is an ingredient in the food product?** \_\_\_\_ yes \_\_\_\_ no  
(Example: Any foods that contain eggs or milk are unacceptable.)

**Explain** \_\_\_\_\_

**2. Explanation of why this disability restricts diet:** \_\_\_\_\_

**3. Major life activity affected by the life threatening food allergy or disability (check all that apply):**

(NOTE: Nederland ISD cannot honor this document unless at least one life activity is marked.)

\_\_\_\_ eating \_\_\_\_ caring for one's self \_\_\_\_ performing manual tasks \_\_\_\_ walking \_\_\_\_ seeing  
\_\_\_\_ hearing \_\_\_\_ speaking \_\_\_\_ breathing \_\_\_\_ learning

**4. Foods to Substitute (NOTE: Nederland ISD cannot honor this document unless substitutions are listed below.)**

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Clinic/Facility Name** \_\_\_\_\_

### RETURN TO SCHOOL NURSE

**Questions? Contact the Child Nutrition Department: 409-724-2391 ext. 1226**

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