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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