

Brenham ISD Child Nutrition Services

Food Allergy/Disability Substitution Request

2017-2018

Student Name: _____ Age: _____

School: _____ Grade/Classroom: _____

Parent/Guardian: _____ Telephone: _____

As a parent or guardian, I give permission for Brenham 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 modifications or substitutions to be made in school meals. This form must be signed by a licensed physician.

Physician's Statement

DIAGNOSES: _____

LIFE THREATENING FOOD ALLERGY – Omit these foods:

_____ Fluid Milk (by itself) _____ Milk (as an ingredient) _____ Peanuts _____ Tree Nuts _____ Eggs
_____ Fish _____ Wheat _____ Soy _____ Other: _____

STUDENTS WITH DISABILITIES: (Please explain disability and the diet modification below).

1. Can the student consume foods where the allergen is an ingredient in the food product? ____yes ____no
(Example: Scrambled eggs are omitted but egg as an ingredient in pancakes is allowed.)

Explain: _____

2. Explanation of why this disability restricts the diet:

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

(Note: Brenham 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 omit _____ Replace With _____ Allowable foods _____

5. Consistency Recommendations: _____ NPO;

Solids: _____ No Solids _____ Puree _____ Mechanical Soft _____ Chopped _____ Regular

Liquids: _____ No Liquids _____ Thin _____ Thickened _____ Nectar _____ Honey _____ Pudding

Physicians Signature _____ Date _____

Telephone _____ Clinical/Facility Name _____

RETURN TO CHILD NUTRITION

Questions? Contact the Child Nutrition Office: 979-277-3750 Fax 979-277-3751

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