



Waller Independent School District Student Diet Modification/Allergy Form

Student Last Name: _____ First: _____ Date of Birth: _____

School: _____ Grade: _____ Student ID: _____

Parent/Guardian Contact Information

Name: _____

Phone Number: _____ Email: _____

I give Health Services/School Nutrition Services permission to speak with the Physician to discuss the dietary needs described below.
Date: _____

Parent/Guardian Signature

Which meals will the student eat from the school cafeteria (please circle)?

BREAKFAST LUNCH NONE (If student does not eat from cafeteria, it is not necessary to complete this form).

The following must be completed by a licensed physician:

Does the student have a **disability or life threatening food allergy** requiring diet modification? *Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a person with "a disability is any person who has a physical or mental impairment that substantially limits one or more life activity" including a life threatening food allergy.*

Yes No *If the student does NOT have a disability and/or life threatening anaphylactic food allergy, this form does not need to be completed and will be disregarded.

Does the student have a prescription for an Epi-pen for a food allergy?

Yes No

Medical Diagnosis: _____

Major life activities affected by the disability: _____

Food to be Omitted:

- Peanuts/Tree Nuts Fish/Shellfish Wheat*
- Fluid Milk All Dairy Products All foods containing milk as an ingredient*(Ex. Breaded items dipped in Milk)
- Eggs by themselves All foods containing egg as an ingredient*(Ex. Baked goods)
- Soy as a main ingredient (Ex. Soy milk, edamame, soy sauce) All foods containing soy as a major ingredient*(Ex. Soy in Processed foods)
- Other: _____

*If student must omit milk or egg as an ingredient, soy as a minor ingredient, wheat, or has multiple food allergies, we may suggest a meal is brought from home or special modifications will be made to accommodate them to receive meals in the cafeteria.

Accommodations Needed:

- Nut free foods
- Seafood free foods
- No Milk/Dairy
- Texture Modified – *Only for student with a medical diagnosis of dysphagia*
 - Pureed
 - Mechanical Soft Chopped
 - Mechanical Soft Ground
 - Other: _____

Name of Licensed Physician (Print): _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

PLEASE RETURN TO SCHOOL NURSE

Questions? EMAIL: mwarzon@wallerisd.net OFFICE: (936)931-2347 FAX: (936)310-6584

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