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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