Return to WISD School Nurse

WEIMAR ISD PHYSICIAN DIET MODIFICATION

SECTION A – To be completed by Parent/Legal Guardian Student's

Name (Last, First) _____ **Date of Birth** _____
School _____ **Grade** _____
Parent/Guardian _____ **Home Phone** _____
Parent/Guardian Email _____

I give Nutrition Services/Health Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Nutrition and Food Service dietitian and the school nurse.

Parent/Guardian Signature _____ **Date** _____

Student has life threatening/anaphylactic food Allergies? ☐ **Yes (complete Section B) No (complete Section C)**

SECTION B: FOOD ALLERGIES - TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY

Peanuts Tree Nuts

Seeds (specify): Sesame Sunflower
Other Seeds (describe)_____

Dairy Allergy (specify): Fluid Milk Only Cheese
Yogurt All Dairy including in baked goods

Egg Allergy (specify): Whole Plain Eggs (ex. Scrambled eggs)
No Eggs in baked goods

No Fish No Shellfish No Wheat

No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk)
No Soy as a minor ingredient (ex. Soy in processed foods, soy oil, soy lecithin)

No Corn as a main ingredient (ex. Corn kernels, corn tortillas)
No Corn as a minor ingredient (ex. Cornstarch, cornmeal, corn syrup, corn oil, corn flour)

Other (please be specific):_____
_____

Substitutions: (Weimar ISD cannot honor this document unless substitutions are listed below)
_____

SECTION C: DISABILITY - TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY

Disability:_____

Major Life Activity affected by the Disability (REQUIRED)
☐ Major Bodily Function ☐ Eating ☐ Breathing
☐ Performing manual tasks ☐ Caring for one's self
☐ Speaking ☐ Learning ☐ Walking ☐ Hearing ☐ Seeing
☐ Other:_____

☐ **Foods to Omit**: _____

Substitutions: (Weimar ISD cannot honor this document unless substitutions are listed below)
_____

Texture Modification Needed? Yes No
Liquids: Thin Nectar Thick Honey Thick Pudding Thick
Solids: Pureed Mechanical Soft (chopped)
☐ Mechanical Soft (ground)

Supplement Needed? Yes No
Supplement:_____
Alternative Supplement: _____
Dosage Per Meal: Breakfast_____ Lunch_____
*Weimar ISD Food Service will attempt to honor requests for supplements based on product availability.
Therapeutic Diet Order: (please provide specifics below)
_____
_____

I certify that the above named student needs to be offered food substitution as described above because of the student's disability and/or life threatening food allergy.

Printed Name of Licensed Physician/Prescribing Medical Authority:_____ Date:_____

Signature of Physician/Prescribing Medical Authority:_____ ☐ MD ☐ DO ☐ PA ☐ NP ☐ SLP

Clinic/Facility Name:_____ Telephone:_____

12/2010, 4/2020