Cypress-Fairbanks Independent School District

Student Diet Modification Form

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

School: _____ Grade: _____

Parent/Guardian Contact Information

Name:_____

Phone Number: _____ Email: _____

I give Health Services/Food Services permission to speak with the Physician to discuss the dietary needs described below.

_____ Date:_____

Parent/Guardian Signature

Which meals will the student eat <u>from the school cafeteria</u> (please circle)?

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

The following must be completed by a licensed physician:

Does the student have a <u>disability or life threatening food allergy</u> 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:_____

Foods to be Omitted:

____Peanuts/Tree Nuts ____Fish/Shellfish/Seafood _____*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 MINOR INGREDIENT*****(Ex.Soy in processed foods)

_____Other:_____

****If student must omit MILK or EGGS AS AN INGREDIENT, SOY AS A MINOR INGREDIENT, WHEAT, or HAS MULTIPLE FOOD ALLERGIES, we must provide them with the Allergen Free Prepackaged Meal in order to accommodate them to receive meals in the cafeteria.****

*****All changes or updates to diet modifications must be provided in writing by a Licensed Physician.*****

Accommodations Needed:

_____Allergen Free Prepackaged Meals- *Free of Gluten, Milk, Egg, All Nuts, Soy, Wheat, Fish, Shellfish* (This menu is available upon request.)

_____Nut free foods _____Seafood free foods _____Soy Milk _____Other_____

_____Dyspaghia Meals- *Only for students with a medical diagnosis of dysphagia*

- **_____Pureed**
- **_____Minced & Moist (Previously Mechanical Soft Chopped)**
- **_____Soft & Bited-Sized (Previously Mechanical Soft)**
- **_____Other:_____**

Does student need thickener provided by nutrition services?: ☐ Yes ☐ No

Please allow two (2) weeks for processing.

Name of Licensed Physician (print): _____

Physician's Signature: _____Date:_____

Address: _____Phone: _____

PLEASE RETURN TO SCHOOL NURSE

Questions? Contact Food Service Dietitian: Katie.Barckholtz@cfisd.net OFFICE: 281-517-2031 FAX: 281-897-4184

updated 5/2017