



THIS SECTION MUST BE COMPLETED BY PARENT/GUARDIAN

Student Name:	Parent/Guardian:
DOB:	Parent/Guardian Contact Number:
Student ID#:	Parent/Guardian Contact Email:
Grade:	

As a parent/guardian, I give permission for Donna ISD to contact the physician's office regarding my child's dietary needs. Yes No

Parent/Guardian Signature

Date

Which meals will the student eat from the school cafeteria (check all that apply)? Breakfast Lunch Supper

MEDICAL DIAGNOSIS

***REQUIRED* THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN OR AUTHORIZED MEDICAL PROFESSIONAL**

1. Does student have a Disability or severe food allergy that is **life-threatening/anaphylactic (must be answered)**? Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, define a person with disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment."

YES, continue with Section A

NO, please complete Section B

2. Does the student have an Epi-pen prescription for food allergy: YES NO

3. Please check the medical diagnosis requiring meal modification/substitution:

Type I/II Diabetes Mellitus PKU Celiac Disease Gastritis/Digestive (specify) _____ Other: _____

4. Please describe the major life activities affected by the disability: _____

SECTION A	OR	SECTION B
Disability or Severe Life Threatening Food Allergy		Non-Life Threatening Allergy/Intolerance
Milk		Milk/Dairy: <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> N/A
<input type="checkbox"/> No Fluid Dairy Milk (drinking) <input type="checkbox"/> No milk/milk products, even as ingredient in cooked or processed foods <input type="checkbox"/> May substitute fluid milk with soy milk <input type="checkbox"/> N/A		<input type="checkbox"/> No fluid milk <input type="checkbox"/> No yogurt <input type="checkbox"/> No cheese <input type="checkbox"/> No milk/milk products, even as ingredient in cooked or processed foods <input type="checkbox"/> May substitute soy milk in place of dairy milk
Soy		Lactose Intolerance
<input type="checkbox"/> Avoid Soy Protein Only <input type="checkbox"/> Avoid soy protein and derivatives (i.e. soybean oil/soy lecithin) <input type="checkbox"/> N/A		<input type="checkbox"/> No fluid milk <input type="checkbox"/> No yogurt <input type="checkbox"/> No cheese <input type="checkbox"/> May provide lactose-free milk
Fish		Soy: <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> N/A
<input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A		<input type="checkbox"/> Avoid Soy Protein Only <input type="checkbox"/> Avoid soy protein and soy derivatives (i.e. soybean oil/soy lecithin)
Eggs		Fish: <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> N/A
<input type="checkbox"/> No eggs, fresh and liquid <input type="checkbox"/> No eggs, even as ingredient in cooked or processed foods <input type="checkbox"/> N/A		<input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Other: _____
Nuts		Eggs: <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> N/A
<input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A		<input type="checkbox"/> No eggs, fresh and liquid <input type="checkbox"/> No eggs, even as ingredient in cooked or processed foods
NOTES:		Nuts: <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> N/A
		<input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Other: _____
	Other	NOTES:
<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> Other _____		
Please check ALL that apply and N/A to the ones that do not apply to student.		

RESTRICTIONS AND LIMITATIONS (must be filled out)

List foods to omit and/or substitutions:

Please specify reactions or limitations student may experience with these foods:

TEXTURE MODIFICATIONS

Does student need texture modifications (Check one): YES NO

- If so, are they needed Year-Round or Temporary: Start _____ to _____

Solids: Pureed (Level 1) Mechanical Soft/Ground (Level 2) Other: _____

Liquids: Nectar Thick (Mild) Honey Thick (Moderate) Spoon Thick (Extreme)

SUPPLEMENTAL NUTRITION

Does student need supplemental nutrition (Check one): YES NO

NPO Supplement to accompany oral diet

Pediasure Pediasure with Fiber Ensure Other: _____

*Supplements may take up to 6 weeks to be processed.

Dosage (REQUIRED): Breakfast Lunch After School/Supper

Physician's Signature

Physician's Full Name, Print: _____

Date: _____

MD DO PA NP

Office/Contact Number:

Please fill out form in its entirety. Check off N/A if it DOES NOT apply to student.

NOTE: After correctly completing this form and form is accepted by CNP Staff, a minimum of **7 days** is needed to accommodate special diet.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

All completed forms may be returned to the School Nurse. Nurse will send to CNP Dietitian email

eugenia.garcia@donnaisd.net