# DONNA INDEPENDENT SCHOOL DISTRICT

## PHYSICIAN'S REQUEST FOR DIET MODIFICATIONS

Campus: _____

Teacher/Nurse: _____

School Year: _____

FORM #1

**THIS SECTION MUST BE COMPLETED BY *PARENT/GUARDIAN***

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

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

**Disability or Severe Life Threatening Food Allergy**

**Milk**

☐ No Fluid Dairy Milk (drinking)

☐ No milk/milk products, even as ingredient in cooked or processed foods ☐ May substitute fluid milk with soy milk

☐**N/A**

**Soy**

☐ Avoid Soy Protein Only

☐ Avoid soy protein and derivatives (i.e. soybean oil/soy lecithin)

☐**N/A**

**Fish**

☐ Fish ☐ Shellfish ☐ Other: _____ ☐**N/A**

**Eggs**

☐ No eggs, fresh and liquid

☐ No eggs, even as ingredient in cooked or processed foods

☐**N/A**

**Nuts**

☐ Peanuts ☐ Tree Nuts ☐ Other: _____ ☐**N/A**

**NOTES:**

**OR**

### SECTION B

**Non-Life Threatening Allergy/Intolerance**

**Milk/Dairy:** ☐ **Allergy** ☐ **Intolerance** ☐**N/A**

☐ No fluid milk ☐ No yogurt ☐ No cheese

☐ No milk/milk products, even as ingredient in cooked or processed foods ☐ May substitute soy milk in place of dairy milk

**Lactose Intolerance**

☐ No fluid milk ☐ No yogurt ☐ No cheese

☐ May provide lactose-free milk

**Soy:** ☐ **Allergy** ☐ **Intolerance** ☐**N/A**

☐ Avoid Soy Protein Only

☐ Avoid soy protein and soy derivatives (i.e. soybean oil/soy lecithin)

**Fish:** ☐ **Allergy** ☐ **Intolerance** ☐**N/A**

☐ Fish ☐ Shellfish ☐ Other: _____

**Eggs:** ☐ **Allergy** ☐ **Intolerance** ☐**N/A**

☐ No eggs, fresh and liquid

☐ No eggs, even as ingredient in cooked or processed foods

**Nuts:** ☐ **Allergy** ☐ **Intolerance** ☐**N/A**

☐ Peanuts ☐ Tree Nuts ☐ Other: _____

**NOTES:**

**Other**

☐ **Allergy** ☐ **Intolerance** ☐ **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.



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

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