Brazosport Independent School District
Child Nutrition ★ Empowering Our Future

Food Allergy Form

Physician's Diet Modifications (Section B & C to be completed by Physician)

A. This section to be completed by parent/legal guardian

If your Child does not have a life threatening allergy or disability requiring diet modification, disregard this form

The U.S. Department of Agriculture School Meals Program requires that **ALL QUESTIONS BE ANSWERED** in order for **ANY** diet modification or substitution to be made in school meals.

Student Name _____Date of Birth: _____ Campus:_____

Parent/Guardian Name _____Phone: _____Email:_____

1. Does your child have a **life threating** food allergy? ___YES ___NO (If "yes", physician must complete section B and Parent must notify school nurse IMMEDIATELY.)
2. Does your child have a disability requiring diet modification? ___YES ___NO (If "yes", physician must complete section C.)

As parent/guardian, I give permission for Brazosport ISD to contact the Physician's office regarding my child's dietary needs.

Signature: _____ Date: _____

B. Physician's statement for student with life threating food allergy

1. Check all **LIFE THREATENING** food allergies – Omit these foods: □ Fluid Milk □ Peanuts □ Tree Nuts □ Eggs □ Fish □ Shellfish □ Wheat □ Soy □ Other (please specify):
   _____
2. Can the student consume foods where the allergen is **an ingredient in the food product**? ___ YES ___ NO
   (Example: scrambled eggs are omitted but egg as an ingredient in pancake is allowed)
   Explain:
   _____
3. **Food to substitute:** *(Note BISD cannot honor this document unless substitutions are listed below)*
   _____

C. Physician's statement for student with Disabilities

1. List any disability requiring meal modification: _____
2. Explanation of why this disability restricts diet: _____
3. Major life activity affected by the DISABILITY (check all that apply):
   □ Eating □ Caring for ones' self □ Performing manual tasks □ Walking □ Seeing □ Hearing □ Speaking
   □ Breathing □ Learning
4. Foods to Omit: _____
5. **Food to substitute:** *(BISD cannot honor this document unless substitutions are listed below)* _____
   _____

_____ _____
Physician's Signature Date

_____ _____
Clinic/Facility Name & Address Telephone

Return completed form to Child Nutrition Office or
Fax completed form to: 979-266-2420 Attention: dietitian