

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 threatening** 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 THREATENING 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**

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