

# Brenham ISD Child Nutrition Services

## Food Allergy/Disability Substitution Request

2019-2020

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade/Classroom: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

*As a parent or guardian, I give permission for Brenham ISD to contact the physician's office regarding my child's dietary needs.* \_\_\_\_\_ *(Parent Signature)*

**The U.S. Department of Agriculture School Meals Program requires that all questions be answered in order for any diet modifications or substitutions to be made in school meals. This form must be signed by a licensed physician.**

### Physician's Statement

**DIAGNOSES:** \_\_\_\_\_

**LIFE THREATENING FOOD ALLERGY** – Omit these foods:

\_\_\_\_\_ Fluid Milk (by itself) \_\_\_\_\_ Milk (as an ingredient) \_\_\_\_\_ Peanuts \_\_\_\_\_ Tree Nuts \_\_\_\_\_ Eggs  
\_\_\_\_\_ Fish \_\_\_\_\_ Wheat \_\_\_\_\_ Soy \_\_\_\_\_ Other: \_\_\_\_\_

**STUDENTS WITH DISABILITIES:** (Please explain disability and the diet modification below).

\_\_\_\_\_  
\_\_\_\_\_

1. 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 pancakes is allowed.)

Explain: \_\_\_\_\_  
\_\_\_\_\_

2. Explanation of why this disability restricts the diet:

3. Major Life activity affected by the life threatening food allergy or disability: (Check all that apply)

(Note: Brenham ISD cannot honor this document unless at least one life activity is marked.)

\_\_\_\_\_ Eating \_\_\_\_\_ caring for one's self \_\_\_\_\_ performing manual tasks \_\_\_\_\_ walking \_\_\_\_\_ seeing  
\_\_\_\_\_ hearing \_\_\_\_\_ speaking \_\_\_\_\_ breathing \_\_\_\_\_ learning

4. Foods to omit \_\_\_\_\_ Replace With \_\_\_\_\_ Allowable foods \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Consistency Recommendations: \_\_\_\_\_ NPO;

**Solids:** \_\_\_\_\_ No Solids \_\_\_\_\_ Puree \_\_\_\_\_ Mechanical Soft \_\_\_\_\_ Chopped \_\_\_\_\_ Regular

**Liquids:** \_\_\_\_\_ No Liquids \_\_\_\_\_ Thin \_\_\_\_\_ Thickened \_\_\_\_\_ Nectar \_\_\_\_\_ Honey \_\_\_\_\_ Pudding

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone \_\_\_\_\_ Clinical/Facility Name \_\_\_\_\_

### RETURN TO CHILD NUTRITION

Questions? Contact the Child Nutrition Office: 979-277-3750 Fax 979-277-3751

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