INTERNATIONAL LEADERSHIP OF TEXAS

Physician's Diet Modification Form

(to be returned to the school nurse and forwarded to Nutrition cashier)

Student's Name: _____ Student ID#: _____ DOB: _____
Parent/Guardian's Name: _____Telephone: _____

As the parent/guardian, I give permission of The International Leadership of Texas to contact the Physician's office noted below regarding my child's dietary needs: _____
(Parent Signature)

The U.S. Department of Agriculture School Meals Program requires that <u>all questions be answered in order for any dietary modification or substitution to be made in school meals. This form must be signed by a licensed physician.</u>

Physician's Statement

I, _____, (Physician) declare the child listed above to possess either a LIFE THREATENING FOOD ALLERGY or a DISABILITY:

LIFE THREATENING FOOD ALLERGY– *OMIT THESE FOODS (CIRCLE ALL THAT APPLY):*

Fluid Milk Peanuts Tree Nuts Eggs Shellfish Wheat Soy Other: _____

OR

DISABLING DIAGNOSIS REQUIRING DIETARY MODIFICATION:

_____

1. Can the student consume foods where the allergen is an ingredient in the food product? __Yes ___ No
Explain (Example: Any foods that contain eggs or milk are unacceptable):

_____

2. Explanation of why this disability restricts diet:

_____

3. Major life activities affected by the life threatening food allergy or disability (check all that apply):
____ eating ____caring for self ____performing manual tasks ____ walking
____ seeing____ hearing ____ breathing ____learning

4. Foods to substitute (substitutions must be noted below)?

_____

Physician's Signature: _____ Date: _____
Clinic/Facility Name: _____ Phone Number: _____