



KATY ISD PHYSICIAN DIET MODIFICATION

SECTION A – To be completed by Parent/Legal Guardian

Student's Name (Last, First) _____ Date of Birth _____

School _____ Grade _____

Parent/Guardian _____ Home Phone _____

Parent/Guardian Email _____

I give Nutrition Services/Health Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Nutrition and Food Service dietitian and the school nurse.

Parent/Guardian Signature _____ Date _____

Student has life threatening/anaphylactic food Allergies? Yes (complete Section B) No (complete Section C)

SECTION B: FOOD ALLERGIES - TO BE COMPLETED BY A LISENCED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY

- Peanuts Tree Nuts
- Seeds (specify): Sesame Sunflower
- Other Seeds (describe) _____
- Dairy Allergy (specify): Fluid Milk Only Cheese
- Yogurt All Dairy including in baked goods
- Egg Allergy (specify): Whole Plain Eggs (ex. Scrambled eggs)
- No Eggs in baked goods
- No Fish No Shellfish No Wheat
- No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk)
- No Soy as a minor ingredient (ex. Soy in processed foods, soy oil, soy lecithin)
- No Corn as a main ingredient (ex. Corn kernels, corn tortillas)
- No Corn as a minor ingredient (ex. Cornstarch, cornmeal, corn syrup, corn oil, corn flour)
- Other (please be specific): _____

Substitutions: (Katy ISD cannot honor this document unless substitutions are listed below)

SECTION C: DISABILITY - TO BE COMPLETED BY A LISENCED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY

Disability: _____

Major Life Activity affected by the Disability (REQUIRED)

- Major Bodily Function Eating Breathing
- Performing manual tasks Caring for one's self
- Speaking Learning Walking Hearing Seeing
- Other: _____

Foods to Omit: _____

Substitutions: (Katy ISD cannot honor this document unless substitutions are listed below)

Texture Modification Needed? Yes No

Liquids: Thin Nectar Thick Honey Thick Pudding Thick

Solids: Pureed Mechanical Soft (chopped)

Mechanical Soft (ground)

Supplement Needed? Yes No

Supplement: _____

Alternative Supplement: _____

Dosage Per Meal: Breakfast _____ Lunch _____

*Katy ISD Food Service will attempt to honor requests for supplements based on product availability.

Therapeutic Diet Order: (please provide specifics below)

I certify that the above named student needs to be offered food substitution as described above because of the student's disability and/or life threatening food allergy.

Printed Name of Licensed Physician/Prescribing Medical Authority: _____ Date: _____

Signature of Physician/Prescribing Medical Authority: _____ MD DO PA NP SLP

Clinic/Facility Name: _____ Telephone: _____

For questions about this form please contact Katy ISD Food Service Dietitian: Danielle Tank, RDN, LD. Phone: 281-396-6240 or email danielletank@katyisd.org

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