Return to School Nurse and Fax to Dietitian at 281-644-1815

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