La Vernia ISD
Student Diet Modification Form

Name of Student (Last, First):_____Date of Birth:_____

Campus:_____Teacher:_____Grade:_____

Parent/Guardian contact information - Name:_____

Phone Number:_____Email:_____

Parent/Guardian Signature:_____Date_____

Which meals will the student eat **from the school cafeteria** (please circle)**?**

Breakfast Lunch None (if the student does not eat in the cafeteria, modifications will not be arranged)

Does the child have a **life-threatening food allergy**? ◯Yes ◯No (if yes, complete **section A**)

Does the child have a **Disability** requiring diet modification? ◯Yes ◯No (if yes, complete **section B**)

** Sections **A** &/or **B** must be completed by a licensed physician.

Section A- Life Threatening Food Allergy

Foods to be omitted from diet:_____

Safe food substitutes:_____

Can the student consume foods where the allergen is an ingredient in a product ? ◯Yes ◯No

(i.e. Can consume eggs in baked goods, but not scrambled eggs)

Can the student consume foods which are manufactured in a facility with peanuts? ◯Yes ◯No

Has the student ever had an anaphylactic reaction to the above listed food? ◯Yes ◯No

Has the student ever had allergy testing indicating an allergy to the above listed food? ◯Yes ◯No

Will Benadryl and/or Epi Pen be provided to the campus: ◯ NO ◯ YES

If student has had an anaphylactic reaction, or positive allergy testing, an allergy action plan and an Epi Pen and/or Benadryl must be provided.

Section B- Disablity Does the student have a disability that restricts the diet? ◯Yes ◯No

Explain:_____

Foods to be omitted from diet:_____

Safe food substitutes:_____ Special Instructions: _____

State licensed healthcare professional (print name) _____ **Phone:** _____

State licensed healthcare professional (signature) _____ **Date:** _____

Food Service Director Signature:_____ **Date:** _____

◯ **APPROVED: Modifications will be made**

◯ **Does not meet requirements for modifications based on the following:**

Revised 3/20/2017