DIBOLL INDEPENDENT SCHOOL DISTRICT
Child Nutrition Department, Attn: Kerri Sanford, Child Nutrition Supervisor
215 N. Temple • Diboll, Texas 75941 • (936) 829-6262 • FAX (936) 829-3106

Nombre: _____ Estudiante ID#: _____ Padre/Tutor: _____

Escuela: _____ Fecha de Nacimento: _____ Numbero de Telefono: _____

****Esta forma NO tiene que ser llenada cada ano. Una nueva forma tendrá que ser llenada en caso que un cambio sea requerido ****

PART A

Si su niño no tiene una alergia a los alimentos o modificación de la dieta especial, por favor firmar a continuación.

Usted puede detener en Parte A. No hay necesidad de completar el resto de este formulario.

Padre/Guardián Firma: _____ Fecha: _____

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 completed and signed by a licensed physician.

PART B

Como padre/tutor, doy permiso para Diboll ISD para ponerse en contacto con la oficina del médico en relación con la dieta de mi hijo.

Padre/Guardián Firma: _____ Fecha: _____

Physician's Statement:

FOR STUDENTS WITH LIFE THREATENING FOOD ALLERGY (must be signed by recognized medical authority – MD, DO, RD, PA, NP)
FOR STUDENTS WITH DISABILITIES (must be signed by physician – MD, DO) **PART C**

Does your child have a life threatening food allergy? ☐ YES ☐ NO

If student has a life threatening allergy, check appropriate box(es). ☐ Ingestion ☐ Contact ☐ Inhalation

Foods to be omitted (circle all that apply):

MILK EGGS PEANUTS TREE NUTS FISH SHELLFISH WHEAT SOY OTHER, specify_____

Can the child consume foods where the allergen is an ingredient in the food product? ☐ YES ☐ NO

(example: Can consume eggs in baked goods, but not scrambled eggs)

Foods to substitute: *(NOTE: Diboll ISD cannot honor this document unless substitutions are listed below.)*

_____

Does the child have a disability? ☐ YES ☐ NO ***If no, skip remaining questions, sign and date at bottom.***

Circle all disabilities requiring meal modification or name disability, if not listed below:_____

Asthma	Emotional Disturbance	Lead Poisoning	Nephritis	Tuberculosis
Autism	Epilepsy	Mental Retardation	Rheumatic Fever	
Cancer/Leukemia	Food Anaphylaxis	Multiple Sclerosis	Sickle Cell Anemia	IMPAIRMENT: (circle below)
Cerebral Palsy	Heart Disease	Muscular Dystrophy	Traumatic Brain Injury	Speech Hearing
Diabetes	Hemophilia			Visual Orthopedic
Drug Addiction/Alcoholism	HIV	Metabolic Disorder, specify _____		

In order to make a diet change, an explanation of how the disability restricts diet is required.

_____

Major life activity affected by the DISABILITY (circle all that apply): *(NOTE: Diboll ISD cannot honor this document unless one life activity is marked.)*

Breathing	Eating	Learning	Seeing	Walking
Caring for one's self	Hearing	Performing manual tasks	Speaking	Other, specify _____

Designate consistency in foods, if a texture change is required. ☐ Chopped ☐ Ground ☐ Pureed ☐ Other

Designate consistency in liquids, if a texture change is required. ☐ Thin ☐ Nectar-like ☐ Honey-like ☐ Spoon-thick

List any special equipment or other comments about the child's eating or feeding patterns.

_____

Physician OR Recognized Medical Authority Signature:_____ Date: _____

Clinic/Facility Name: _____ Telephone: _____

RETURN TO SCHOOL NURSE

Questions? Contact the Child Nutrition Department: (936) 829-6262 Received by Nurse: _____ Received by Child Nutrition: _____

Update: 4/14/14