



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 Nacimiento: _____ Numero 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) PART C
FOR STUDENTS WITH DISABILITIES (must be signed by physician – MD, DO)

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: _____

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