MESQUITE ISD Food & Nutrition Services - PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name_____ Student Name_____

Campus Name_____ Date of Birth _____

As parent or guardian, I give **permission for Mesquite ISD to contact the Physician's office regarding my child's dietary needs.**

_____ (Parent/Guardian Signature)

PART A – If your child has a food allergy or special diet but will NOT eat food from the Mesquite ISD cafeteria, please sign below. There is NO NEED TO COMPLETE the rest of this form if your child will not eat in the cafeteria.

_____ _____

Parent/Guardian Signature Telephone

PART B – STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY MUST HAVE THIS SECTION COMPLETED BY A PHYSICIAN.
(If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART C on back of page.)

PHYSICIAN'S STATEMENT Date _____

I declare the child listed above to possess a LIFE THREATENING FOOD ALLERGY.

_____
Physician's Name (please PRINT)

1. Life threatening food allergy – Circle all foods that must be omitted:

____fluid cow's milk ____ peanuts ____tree nuts ____eggs ____fish ____shellfish ___wheat ___soy

Other life threatening food allergy, specify _____

2. Can the student consume foods where the allergen is an ingredient in the food product? ____ yes ____ no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)

Explain_____

_____

3. Explanation of why this disability restricts diet: _____

4. Major life activity affected by the life threatening food allergy (check all that apply):
(*NOTE: Mesquite ISD cannot honor this document unless at least one life activity is marked.)*

____ eating ____caring for one's self ____performing manual tasks ____walking
____ hearing ____ speaking ____breathing ____learning ____seeing

5. Foods to Substitute (*NOTE: Mesquite ISD cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or physician refers patient to registered dietitian who specifies menu items.)*

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Telephone Clinic/Facility Name & Address

MESQUITE ISD Food & Nutrition Services - PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name_____ Student Name_____

Campus Name_____ Date of Birth _____

As parent or guardian, I give **permission for Mesquite ISD to contact the Physician's office** regarding my child's dietary needs.

_____
(Parent/Guardian Signature)

PART C – STUDENTS WITH DISABILITIES MUST HAVE THIS SECTION COMPLETED BY A PHYSICIAN.

PHYSICIAN'S STATEMENT Date _____

I declare the child listed above to possess a DISABILITY. _____
Physician's Name (please PRINT)

1. Check all disabilities requiring meal modification:

___autism ___muscular dystrophy ___heart disease ___hemophilia ___asthma ___cerebral palsy ___ multiple sclerosis ___HIV ___rheumatic fever ___sickle cell anemia ___epilepsy ___cancer/leukemia ___tuberculosis ___nephritis ___lead poisoning ___speech impairment ___traumatic ___brain injury ___emotional disturbance ___visual impairment ___orthopedic impairment ___drug addiction/alcoholism ___hearing impairment mental retardation metabolic disorder, specify _____

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

3. Major life activity affected by the DISABILITY (check all that apply):
(*NOTE: Mesquite ISD cannot honor this document unless at least one life activity is marked.)*

____ eating ____caring for one's self ____performing manual tasks ____walking ____seeing ____ hearing ____ speaking ____breathing ____learning ____ other, specify_____

4. Foods to Omit:
_____

_____

5. Foods to Substitute (*NOTE: Mesquite ISD cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or Physician refers patient to registered dietitian who specifies menu items.)*
_____

_____

_____ _____
Physician's Signature Date

_____ _____
Telephone Clinic/Facility Name & Address

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Mesquite ISD Child Nutrition Department
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